MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-d)

CERTIFICATE OF DEATH

15769

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore

City or town Halla Nora

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Essex Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Halla Nora

(If outside city or town limits, write RURAL and give nearest town)

Street No. Essex Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Annie Adams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Wm. K. Adams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1864

8. AGE: Years	Months	Days	If less than one day
80	9	13	..... hrs. ..... min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Elliott

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Geo. W. Tucker

Address 4712 Elsroda Ave. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/15/45 (month) (day) (year)

Cemetery or crematory Lorraine

Location Baltimore Co.

18. Funeral director Harry Waterbase

Address 4110 Edmondson Ave

19. 6/13/45 (Date rec'd by registrar) Wm. E. Martus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1943 to June 13, 1945

and that I last saw her alive on June 12, 1945

Immediate cause of death	DURATION
Carcinoma of Vulva	
Due to Carcinoma of Vulva	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm. E. Martus M. D. or other

Address Randallstown Date signed 6/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

05779

V. S. No. 1

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (330)

County Baltimore Registration Dist. No. 35

Village or City Towson No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Morrison Alrich

(a) Residence: No. 200 Maryland Ave Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	Wht	Single

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day, and year) Oct 22 1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	7	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housekeeper

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Delaware

FATHER

13. NAME Lucas Alrich

14. BIRTHPLACE (city or town) (State or country) Delaware.

MOTHER

15. MAIDEN NAME Matilda Conn

16. BIRTHPLACE (city or town) (State or country) Delaware.

17. INFORMANT Mrs John Morris (Address) 200 Md ave

18. BURIAL, CREMATION, OR REMOVAL Place Cheltenham Md Date 6/19/45

19. UNDERTAKER Geo H. Lembach (Address) 525 N. Eyndhurst St

20. FILED 6/18, 1945 D. G. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June (Month) 16 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov., 1940, to June 16, 1945; I last saw h[illegible] alive on June 15, 1945; death is said to have occurred on the date stated above, at 11:45 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral arteriosclerosis	1938
Other Contributory Causes of Importence: Cerebral Hemorrhage	2 hrs. 1945

Neme of operation Date of

Whet test confirmed diegnosis? Wes there en autopsy?

23. If deeth wes due to external ceuses (VIOLENCE) fill in elso the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Neture of injury

24. Was diseese or injury in any wey related to occupation of deceesed? No

If so, specify

(Signed) A. S. Christian M. D.

(Address) 6210 Northern

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(PC 05771 P)

Reg. Dist. No.

1. PLACE OF DEATH:

County BALTIMORE

City or town BALTIMORE Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

HOODS CONVALESCENT HOME 5313 EDMONDSON AVE.

Stay in hospital or inst. (yrs., or mos., or days) 2 YEARS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BALTO.

City or town BALTIMORE MD. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1231 N. LONGWOOD ST.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME MARY AMON

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 16 1863

8. AGE: Years 81 | Months 9 | Days 19 | If less than one day ___ hrs. ___ min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual occupation HOUSE WORK

11. Industry or business AT HOME

FATHER 12. Name JOHN AMON

13. Birthplace GERMANY

MOTHER 14. Maiden name CATHERINE MAY

15. Birthplace GERMANY

16. Informant MARY APPEL (COUSIN)

Address 1231 N. LONGWOOD ST.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 7/45 (month) (day) (year)

Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18. Funeral director Sally Zeiler Sr.

Address 403 S. WOLFE ST.

19. 6-6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 4 1945, at 6 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 4 1945, and that I last saw h[illegible] alive on June 4 1945.

	DURATION
Immediate cause of death Cer. Thrombosis	6 mon
Due to Generalized Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 715 Frederick Rd Date signed 6/5

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(93a)

Registered No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Co.
(a) Baltimore ~~City~~, Maryland
(b) Street address 5313 Edmondson Ave.
(c) Hospital or institution: Hoods Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED: C5772
(a) State Md. (b) County Balto.
(c) City or town Catonsville,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Hilton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna A. Barthel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years about 74 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation retired school teacher

11. Industry or business

FATHER
12. Name Unk
13. Birthplace "

MOTHER
14. Maiden Name Unk.
15. Birthplace "

16 (a) Informant Mr. Wm. F. Barthel
(b) Address 4810 Erskine Rd. College Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore,
Location Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Williams, M.D.

JUN 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to 6/27 1945, and that I last saw her alive on 6/27 1945.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Acute Myocarditis	Unknown
Due to Arteriosclerosis	
Other Conditions See Cty	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Thomsen M. D.
Address 4012 Edmondson Ave. Date signed 6/28/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

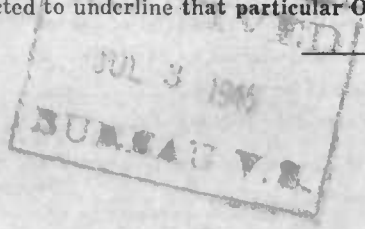
If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 306

CERTIFICATE OF DEATH

(5773

★

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 23 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 7 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: 3709 Taylor Avenue

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Brentwood,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Amelia Becker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 11, 1911

8. AGE: Years	Months	Days	If less than one day
33	6	25	hrs. min.

9. Birthplace: Dubuque, Iowa (Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: Dept. of Internal Revenue

FATHER — 12. Name: George A. Becker

FATHER — 13. Birthplace: Iowa

MOTHER — 14. Maiden name: Katherine Moritz

MOTHER — 15. Birthplace: Luxembourg

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/5/1945 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Wm. J. Malley

Address: 3200 N. J. Ave. Mt. Rainier, Md.

19. 6/5 19 45 (Date rec'd by registrar) Y. C. Sanders Deputy Registrar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 19 45, at 8:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 44, to June 5 19 45 and that I last saw her alive on June 5 19 45

Immediate cause of death	DURATION
Terminal pneumonia	24 hours
Due to: General paresis	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

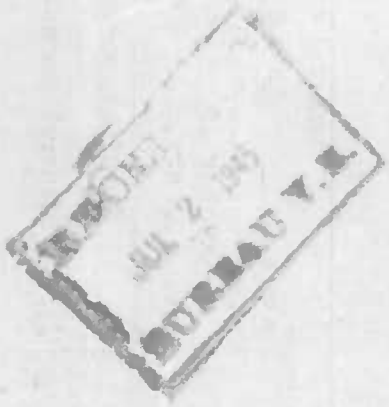
Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robt. E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 6/5/45


JUL 2
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23rd)

CERTIFICATE OF DEATH

05774

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 110 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 110 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

aa.

State: Maryland County:

City or town: Box 368 Lincoln Hgts.,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: See above
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: WILLIAM T. BERRY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Helen Berry

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 9-14-88

8. AGE:	Years	Months	Days	If less than one day
	56	9	14	...hrs. ...min.

9. Birthplace: Glouchester, Va.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER 12. Name: Alfred Berry

13. Birthplace: Virginia

MOTHER 14. Maiden name: Nannie Holmes

15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 30, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

16. Funeral director: A. Lee Oder

Address: 4644 York Road, Balto., Md.

19. June 29 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28, 1945 19... at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1945 19... to June 28, 1945 and that I last saw him alive on June 28, 1945 19...

	DURATION
Immediate cause of death: Cerebral Embolism	1-1/2 Hrs.
Due to: Disease of the Heart	
Cause: Coronary Arteriosclerosis,	
Due to: Structural Lesions: Cardiac enlargement; Myocardial damage	
Other conditions: Manif: Myocardial Insufficiency; Auricular fibrillation	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. Balter

A. M. BALTER, LT. COL., M.C. ASST. DIR.

Address: Ft. Howard, Maryland Date signed: 6-28-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

65775

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Mount de Sales Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs

Hospital, Institution, or street address where death occurred:
Edmondson Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Edmondson & Runnemede Ave
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Sister Mary Alphonsa Blank

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17, 1873

8. AGE: Years 72 | Months 3 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual occupation Nurse

11. Industry or business

FATHER 12. Name Frederick Blank

13. Birthplace Germany

MOTHER 14. Maiden name Paula Selg

15. Birthplace Germany

16. Informant Mount de Sales records

Address Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28, 1945 (month) (day) (year)

Cemetery or crematory Mount de Sales Cem.

Location Catonsville Md.

18. Funeral director Easton Sons

Address 608 Frederick Ave. Catons Md.

19. 6/28 1945 (Date rec'd by registrar) K. C. Andrews Registrar Deputy Local Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945, at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5, 1945, to June 27 1945 and that I last saw her alive on June 24 1945

Immediate cause of death Cardio-vascular-renal Disease — DURATION: 4 mos 22 days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results None No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thomas M. Monaghan M. D. or other

Address Catonsville, Md. Date signed 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


JUL 3 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

05776

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

City or town 16 Fusting Ave. Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Carter's Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Fusting Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME anna M. Boden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Albert J. Boden

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1870

8. AGE: Years	Months	Days	If less than one day
74 yrs.	8	16	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Henry Strauch

13. Birthplace Germany

MOTHER 14. Maiden name Catherine Rott

15. Birthplace Bavaria

16. Informant Mr. Herbert E. Hampton

Address 3111 Walbrook Ave.

17. Burial Date thereof 6/20/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 6/19 1945 C. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 3.20 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 18 1944, to June 17 1945 and that I last saw h.... alive on June 16 1945

Immediate cause of death	DURATION
Myocardial Decompensation	2 wk.
Due to Generalized Arteriosclerosis.	?
Due to	
Other conditions Senile Dementia	5 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D.
M. D. or other

Address Catonsville-28, Md. Date signed 6-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

C5777 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH

County Baltimore Co.

City or town Mr. Essex Holabird Neck Road

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County Co

City or town 5415 Maywiew Ave Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5415 Maywiew Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Minnie M. Bozman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Earl D.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1- 1906

8. AGE: Years 38 | Months 9 | Days | If less than one day hrs. min.

9. Birthplace Carlisle Pa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Sargent

FATHER 13. Birthplace Pa

MOTHER 14. Maiden name Sarah Morrison

MOTHER 15. Birthplace Pa.

16. Informant Mr Earl D Bozman

Address 5415 Maywiew Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-3-45 (month) (day) (year)

Cemetery or crematory Moreland Pk

Location

18. Funeral director Leonard J. Reed

Address 3305 Hilford Rd

19. 7/3 1945 A.W. Wedril Registrar

(Date filed by registrar)

D-M

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to June 30 1945

and that I last saw her alive on June 29th 1945

Immediate cause of death	DURATION
Mitral Rheumatic Heart Disease	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Daniel Goldstein M. D. or other

Address 319 Med Arts Date signed 7/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of date of death is shown on FILM No. G 97 AUG 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05778 Reg. Dist. No. 42

1. PLACE OF DEATH:
County: BALTO CO
City or town: HALETHROPE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, Institution, or street address where death occurred: 4501 LINDEN AV.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: BALTO CO
City or town: HALETHROPE
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4501 LINDEN AV.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BLANCHE A. BREIVOGEL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: HARRY J.
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): APR. 29 1884

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
61	1	19		

9. Birthplace: CORDOVA, TALBOT CO., MD
(Town, county, and state)
10. Usual occupation: HOUSE WIFE
11. Industry or business

FATHER
12. Name: NICHOLAS CALLAHAN.
13. Birthplace: TALBOT CO., MD.

MOTHER
14. Maiden name: ANNA GANNON
15. Birthplace: TALBOT CO MD

16. Informant: HARRY J BREIVOGEL
Address: 4501 LINDEN AV. - HALETHROPE MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6-22-45 (month) (day) (year)
Cemetery or crematory: LONDON PARK. CEM.
Location: FREDRICK AV. BALTO, MD

18. Funeral director: JOHN R KENNY.
Address: 1242 LEEDS TER, ARBUTUS, MD

19. 6/21/45 (Date rec'd by registrar) E. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 19, 1945 et M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1920, to June 20 1945
and that I last saw h[illegible] alive on June 16 1945

Immediate cause of death	DURATION
1 hr. Myocarditis	1 Yr
Typhoid fever.	
Due to	
Due to	
Other conditions: Sudden decompensation	1 hour

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of ✓
Where did injury occur? ✓ (City or town) ✓ (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frederick N. Bieler M. D. or other
Address: Medical Arts Bldg - Date signed 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (83-2)

Reg. Dist. No. P 43

CERTIFICATE OF DEATH

05779

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Overlea Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 12 E. Overlea Avenue
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) 22 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E. Overlea Ave —
(If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** James Michael Brooks

3 (b) If veteran, name war —

3 (c) Social Security No. 212-01-2412

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Babette Brookes

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1882

8. AGE: Years 62 | Months 9 | Days 26 | If less than one day _____ hr. _____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Landscaper.

11. Industry or business

FATHER
12. Name Michael Brooks.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Catherine Butler
15. Birthplace Baltimore.

16 (a) Informant Mrs. J. M. Brooks.
(b) Address 15 E. Overlea Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Harford Road

18 (a) Funeral director John Conaughton
(b) Address 901-903 Hollins St.

19 (a) June 12, 1945 (State rec'd by registrar) (b) A. H. Bedrick Registrar

A.E.S.

MEDICAL CERTIFICATION

20. Date of death June 10 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 10 1945, and that I last saw him alive on June 10 1945.

Immediate cause of death	Duration
Cerebral apoplexy	Sudden
Due to Multiple sclerosis	
Due to Cerebral	
Due to	
Other conditions Parkinsonism disease	8 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. M. Baumgardner M. D. or other
Address Balto 6 Md Date signed 6/10/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

C5781

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 41 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: S. Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1026 17th St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: HENRY JAMES BROWN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Virginia Brown
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Sept. 25, 1898

8. AGE: Years	Months	Days	If less than one day
46	8	13	...hrs. ...min.

9. Birthplace: Chicago, Ill
(Town, county, and state)
10. Usual occupation: Attorney
11. Industry or business

FATHER
12. Name: Henry J. Brown
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Sarah F. Adams
15. Birthplace: Illinois

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (month) (day) (year)
Cemetery or crematory: Oakhill Cemetery
Location: Chicago, Ill.

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 6-9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945 19..., at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1945 19... to June 8, 1945 19... and that I last saw him alive on June 8, 1945 19...

Immediate cause of death	DURATION
CARCINOMA OF STOMACH	6 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: J.N. Amy Balter
A. M. BALTER, LT. COL., M.C. CLIN. DIR.
Address: Ft. Howard, Md. Date signed 6-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05781

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92b)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Baltimore
City or town Halethorpe (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Baltimore
City or town Halethorpe (If outside city or town limits, write RURAL and give nearest town)
Street No. 4501 Spring Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Bryant
3. (b) Social Security Number 215-14-5718

4. Sex Male
5. Color or race Col.
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Eunice May
6.(c) If alive, give age ___ years
7. Birth date of deceased (mo., day, yr.) Dec. 13, 1894

8. AGE: Years	Months	Days	If less than one day
50	—	—	hrs. min.

9. Birthplace Jamaica, B.W.I. (Town, county, and state)
10. Usual occupation Janitor
11. Industry or business
FATHER 12. Name Thomas Bryant
13. Birthplace B.W.I.
MOTHER 14. Maiden name Rosa ???
15. Birthplace B.W.I.
16. Informant Eunice May Bryant
Address 4501 Spring Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4, 1945 (month) (day) (year)
Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.
18. Funeral director Mrs. Geo. H. Holland
Address 1631 Druid Hill Ave.
19. 6/2 19 45 (Date rec'd by registrar) K. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1945, at 4:55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-5-45 19 , to 6-1-45 19 and that I last saw him alive on 6-1-45 19

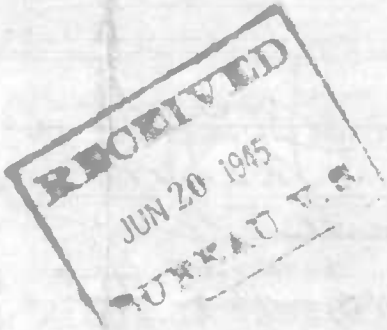
Immediate cause of death	DURATION
Mitral Insufficiency	?
Due to Arterio-sclerosis	?
Due to	

Other conditions \ \
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. F. Maloney M.D. M. D. or other
Address Catonsville, Md. Date signed 6/2/45

VS A15


RECEIVED
JUN 20 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

★15782

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Mount Wilson, Baltimore County
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 1 mo., 6 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 1 mo., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Luna Mae Burchett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lester Burchett
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): July 24, 1896

8. AGE: Years	Months	Days	If less than one day
48	10	25	...hrs. ...min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:

FATHER
12. Name: David L. Grace
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Isabelle Minton
15. Birthplace: North Carolina

16. Informant: Mrs. Luna Mae Burchett
Address: Churchville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, 1945 (month) (day) (year)
Cemetery or crematory: Oak Grove Cemetery
Location: Harford Co., Maryland

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Maryland

19. June 18, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1945 at 8:55 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1945 to June 18, 1945 and that I last saw her alive on June 18, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr
Due to: Tubercle Bacilli	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Thomas J. O'Neill, M.D. M. D. or other
Address: Mount Wilson, Md. Date signed 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170)

CERTIFICATE OF DEATH

05783 P

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Baltimore
City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months
Hospital, institution, or street address where death occurred:
Route 1 Kingsville Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County:
City or town: Burlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Kingsville Md
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Benjamin J. Burnett

3.(b) Social Security Number: 245-12-6740

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Anna Burnett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1887

8. AGE: Years: 58 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Hotel

FATHER
12. Name: Charles L. Burnett
13. Birthplace: N. C.

MOTHER
14. Maiden name: Caroline Craig
15. Birthplace: N. C.

16. Informant: Sidney Burnett
Address: 1508 N. Mount St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6 8 45 (month) (day) (year)
Cemetery or crematory: Burlington N. C.
Location: Burlington N. C.

18. Funeral director: Mrs Katie R Williams
Address: 322 A Schroeder St

19. June 6 19 45 (Date rec'd by registrar) A.W. Hedrick (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1945, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral Hemorrhage — Fractured skull	6/4/45
Due to: Striking head on pavement — struck by auto	6/4/45
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: June 4, 1945.
Where did injury occur? Kingsville (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public Highway
Means of injury: Struck by auto Injured at work? No

23. SIGNATURE: Rollin C. Hudson MD. DMD (M. D. or other)
Address: Towson 4, Md. Date signed: 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

6/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05784

Reg. Dist. No. 22

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred:
Orchard Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Orchard Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph J. Cairns Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1898

8. AGE: Years	Months	Days	If less than one day
47	1	21	hrs. min.

9. Birthplace Montreal, Canada (Town, county, and state)
10. Usual occupation Gardner
11. Industry or business

FATHER
12. Name Joseph J. Cairns
13. Birthplace Ireland

MOTHER
14. Maiden name Margaret E. Keagan
15. Birthplace Ireland

16. Informant Mary Vian
Address Orchard Rd. Pikesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/16/45 (month) (day) (year)
Cemetery or crematory David Ridge
Location Pikesville, Maryland

18. Funeral director Frank H. Purnell
Address Pikesville, Md.

19. 6-15-1945 (Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 5-20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1944, to June 17 1945
and that I last saw h. in alive on June 12 1945.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 hr
Due to: Arterial Hypertension	3
Due to:	
Other conditions: Diabetes Mellitus	several years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E E Nichols M.D. M. D. or other
Address Pikesville Md Date signed 6/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JUN 16 1945
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05785 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Point. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
614 F st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Sharrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 614 F st.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Lillian Estar Carroll

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Albert E Carroll Sr.
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) Nov-1-1898

8. AGE: Years	Months	Days	If less than one day
46	7	28	...hrs. ...min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name Sam Hoover
13. Birthplace Md

MOTHER
14. Maiden name Cora Hendrix
15. Birthplace Md

16. Informant Albert E Carroll
Address 614 F St. Sparrows Point Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/5/45 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Baltimore Co Md
18. Funeral director William Corkran
Address 1319 E Cold St
19. 7/3 19 45 Alb Bedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 45, at 10 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 45, to June 29 19 45
and that I last saw h...alive on June 29 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hrs.
Due to Hypertensive cardiovascular disease	3 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A B Windsor, M.D. M. D. or other
Address 5 20 D St Sp Pt 19 Date signed 7-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05786 R

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Anneslie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Anneslie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1020 Regester Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary E. Caulk.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife** James M. Caulk
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 24. 1869

8. AGE: Years	Months	Days	If less than one day
75	9	11	..... hrs. ..... min.

9. Birthplace Baltimore Maryland.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name Thomas E. France
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah J. Brown
15. Birthplace Maryland

16. Informant Mrs Miriam G. Glauber
Address 1020 Regester Ave, Anneslie.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/7/1945 (month) (day) (year)
Cemetery or crematory Mount Olivet
Location Frederick Ave, Baltimore.
18. Funeral director Howard A. Gill
Address 19 W. Pennsylvania Ave, Towson

19. 6/6 19 45 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4. 19 45 at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1st. 19 45 to June 4. 19 45
and that I last saw h. ex alive on June. 4 19 45

Immediate cause of death	DURATION
Coronary Occlusion	4 days
Due to —	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 524 York Rd Date signed 6.5.45

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (1378)

Reg. Dist. No. 42

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:
6700 Dogwood Road

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)

(d) Street No. 6700 Dogwood Road
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Henry Edwards Clarke

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4, 1880

8. AGE: Years	Months	Days	If less than one day
65	5	14	____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Henry Edwards Clarke
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Sangston
15. Birthplace Calvert County, Md.

16 (a) Informant Miss Elizabeth Jeffries
(b) Address 6700 Dogwood Road, Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20, 1945 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cemetery

Location Baltimore, Md.

18 (a) Funeral director J. Wilbur Lamoreaux

(b) Address 4510 Liberty Heights Ave.

19 (a) Jan 18 45 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death June 18 1945, at 4.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw him alive on ____ 19____.

Immediate cause of death	Duration
Acute Cardiac failure	
Due to	
Due to Diabetes Vascular	
Other conditions Renal disease	
sudden death Ingmg	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** [signature] M. D. or other

Address 1010 Leeds St. Arbutus, Md.

Date signed 6-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-E)

CERTIFICATE OF DEATH

0:5789

★ Reg. Diat. No. 30

1. PLACE OF DEATH:
County Balto.
City or town 313 Shadynook Ave. Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 313 Shadynook Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Mary Slade Cockey

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	W.

6.(b) Name of husband or wife Mordecai Cockey
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 2, 1853

8. AGE: Years	Months	Days	If less than one day
91	3	11	...hrs. ...min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business —
FATHER 12. Name John Slade
FATHER 13. Birthplace Harford Co. Md
MOTHER 14. Maiden name Mary Amos
MOTHER 15. Birthplace Harford Co.
16. Informant Sally Montgomery Cockey
Address 313 Shadynook Ave. Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory All Saints
Location Reisterstown, Md.
18. Funeral director Wm. Berryman & Sons
Address Reisterstown, Md.
19. 6/14 19 45 (Date rec'd by registrar) E. C. Landvoigt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 45 at 11:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 19 28 to June 13 19 45
and that I last saw h[illegible] alive on June 13 19 45

Immediate cause of death	DURATION
Gastro-Enteritis	3 days
Due to Senility	10 years
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide D Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury D Injured at work?

23. SIGNATURE S. Lloyd Johnson M.D.
M. D. or other
Address Catonsville, Md. Date signed 6-14-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth is shown on FILM No. G 96 JUL 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore (183)

CERTIFICATE OF DEATH

05789

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore, County
City or town Ruxton, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1514 Madison Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laurence Cook

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	colored	single

6 (b) Name of husband or wife none
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25 - 1932 1931

8. AGE: Years	Months	Days	If less than one day
13	8		hrs. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual occupation Student
11. Industry or business
FATHER 12. Name Robt. Cook
13. Birthplace North Carolina
MOTHER 14. Maiden name Florence Williams
15. Birthplace Petersburg, Va.
16. Informant Mrs Florence Cook
Address 1514 Madison Ave.
17. Burial Date thereof June 19 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore, Md
18. Funeral director Mrs Geo. H. Holland
Address 1631 Druid Hill Ave
19. June 18 19 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1945, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from none 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Drowning, accidental (while swimming) — DURATION 6/15/45

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Collin C. Hudson M.D. D.M.E.
M. D. or other
Address Towson 4, Md Date signed 6/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-2)

CERTIFICATE OF DEATH

★ 05790

Reg. Diat. No. 40

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Baltimore

City or town Bradshaw

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Bradshaw

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Annie Elizabeth Corbin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife Charles Corbin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12, 1874

8. AGE: Years	Months	Days	If less than one day
70	11	2	..... hrs. ..... min.

9. Birthplace Upper Falls Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Fred Schutz

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Annie E. Owens

15. Birthplace Philadelphia Pa

16. Informant Charles Corbin

Address Bradshaw Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27 1945 (mooth) (day) (year)

Cemetery or crematory Franciscanville Presbyterian

Location Franciscanville Maryland

18. Funeral director Howard K. McComas Son

Address Abingdon Maryland

19. June 27 1945 (Date rec'd by registrar) Clarence E. Arthur Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 11:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 21 1945, to June 24 1945

and that I last saw h.. alive on June 24 1945

	DURATION
Immediate cause of death Left hemeplegia	5-21-45
Due to Essential hypertension	Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fred O. Hodous, M.D. M. D. or other

Address Edgewood, Md Date signed 6-24-45

VS A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ 05791

Reg. Diat. No. 38

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
37 Alleghaney Avenue

How long in hospital or institution? ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 Alleghaney Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war ----------

3. (a) FULL NAME

LIDA WATKINS CRAUMER

3. (b) Social Security Number

------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: W. Clarence Craumer

6.(c) If alive, give age ----- years

7. Birth date of deceased (mo., day, yr.): March 11, 1873

8. AGE: Years	Months	Days	If less than one day
72	2	28	....hrs. ....min.

9. Birthplace: Towson, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER 12. Name: John Maurice Watkins, Sr.

13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary Louisa Eckhart

15. Birthplace: Maryland

16. Informant: Mrs. H. Dalton Berry

Address: 12 Burke Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10, 1945 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cemetery

Location: Towson, Maryland

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. June 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 6th 1945 to May 8 1945 and that I last saw h.. alive on June 7th 1945

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	1 week.
Due to Generalized Sclerosis	2 mos.
Due to Myocardial insufficiency	
Chronic Endocarditis	
Other conditions Chronic Interstitial Nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ....Injured at work?

23. SIGNATURE: Daniel Jos. Thos. Jenifer M. D. or other

Address: June 7th, 1945 Towson, Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

05792

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Sollers Point Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore.
City or town: Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Sollers Point Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: Reond Merritt Farm

3.(a) FULL NAME Sadie Margaret Croswell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widow.

6.(b) Name of husband or wife: Hiram T.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 30/1857

8. AGE: Years: 87 | Months: 9 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Dorchester Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Jacob Insley
13. Birthplace: Md.

MOTHER
14. Maiden name: Leah Etta Turner
15. Birthplace: Md.

16. Informant: Mrs. Richd Merritt.
Address: Dundalk. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: June 18 1945 (month) (day) (year)
Cemetery or crematory: Roseland Cemetery
Location: Reedville, Va.

18. Funeral director: Lankford Funeral Home
Address: 7401 Belair Road

19. June 16 1945 (Date rec'd by registrar) Dawson L. Harlan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1945 at 11.0 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29 1944 to June 15 1945
and that I last saw her alive on June 12 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to: Cardio Vas. Renal Disease & Hypertension	
Due to: Fracture Femur:	2 mo.
Due to: Accidental Fall in Home	
Other conditions: Fell & arising from her chair.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Oct. 29, 1944
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): At home
Means of injury: Accidental Fall. Injured at work?

23. SIGNATURE: D M Carmine M.D.
M. D. or other
Address: Dundalk Md. Date signed: 6/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05793

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 8 mos., 4 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 2 yrs., 8 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 918 William Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert M. Davis

3.(b) Social Security Number: 212-07-9275

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 29, 1905

8. AGE: Years	Months	Days	If less than one day
39	7	17	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Paper Hanger
11. Industry or business:

FATHER
12. Name: George Davis
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Alice McCubbin
15. Birthplace: Baltimore, Maryland

16. Informant: Albert M. Davis
Address: 918 William St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Annapolis Rd., Anne Arundel Co., Md.

18. Funeral director: John F. Denney, Jr.
Address: 715 Light St., Balto., Md.

19. 6/15/45 (Date rec'd by registrar) 19 45 Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15, 1945, 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 1942 to June 15, 1945 and that I last saw him alive on June 15, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yrs
Due to: Tubercle Bacilli	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas J. O'Neill M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 6-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Cane put in mailbox upstairs

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

05794

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

16 Frustum Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Frustum Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary E Walmsley Deane

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Arthur S.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1865

8. AGE: Years: 80 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Alfred Walmsley

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Not Available

MOTHER — 15. Birthplace: England

16. Informant: Arthur S Deane

Address: Baker Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-13-45 (month) (day) (year)

Cemetery or crematory: Mt Peace

Location: Philadelphia Pa

18. Funeral director: Geo A Talley

Address: Catonsville Md

19. 6/19 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 19 45, at 7 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 19 43, to June 11 19 45

and that I last saw h[illegible] alive on June 20 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 mo
Due to: Arteriosclerosis	7.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilson K Gallagher M.D. M. D. or other

Address: Catonsville, Md Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

05795

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Facility, Fort Howard, Maryland

How long in hospital or institution? 27 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Market Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: WILLIAM R. DELGAR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Anna Delgar

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 1-21-98

8. AGE: Years	Months	Days	If less than one day
47	5	7	..... hrs. ..... min.

9. Birthplace: Sumpter, S. C.
(Town, county, and state)

10. Usual occupation: Storekeeper

11. Industry or business:

FATHER
12. Name: William Robert Delgar
13. Birthplace: Sumpter, S. C.

MOTHER
14. Maiden name: Hattie Brown
15. Birthplace: Sumpter, S. C.

16. Informant: Clinical Records, Vets., Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30-1945 (month) (day) (year)

Cemetery or crematory: Bakers Cemetery

Location: Belair Rd., Aberdeen, Md.

18. Funeral director: John Tarring

Address: Aberdeen, Md.

19. 6/28/45 a.w. Hedrick (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28, 1945 19.... at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945 19.... to June 28, 1945 and that I last saw him alive on June 28, 1945 19....

Immediate cause of death	DURATION
Coronary Occlusion	2 Hrs.
Due to: Disease of the Heart:	4 Yrs.
Cause: Coronary Arteriosclerosis	
Due to: Structural Lesion: Myocardial Damage	
Manif.: Anginal Syndrome	
Other conditions: Diabetes Mellitus	15 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. BALTER, LT.COL., M.C. CHIEF MED. DIR.

Address: Fort Howard, Maryland Date signed: 6-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of date of birth of deceased is shown on

FILM No. G 98 OCT 4 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-6)

CERTIFICATE OF DEATH

05796

★ Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 73 Edmondson Ridge Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 73 Edmondson Ridge Rd (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Valerie Demmitt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1916 ~~Jan 28 1917~~

8. AGE: Years: 28 | Months: 4 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: Atty's Office

FATHER — 12. Name: Adam Lang Demmitt

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Dallia Plante

MOTHER — 15. Birthplace: New York

16. Informant: Mrs. Dallia Demmitt

Address: 73 Edmondson Ridge Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-9-45 (month) (day) (year)

Cemetery or crematory: St Charles Cem

Location: Pikesville Md

18. Funeral director: Geo. C. Talley

Address: Catonsville Md

19. 6/8 19 45 (Date rec'd by registrar) H. C. Gundel Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 19 45, at 10.55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 19 45 to June 6 19 45 and that I last saw h. alive on June 6 1945 19

Immediate cause of death	DURATION
Subacute Endocarditis & Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Albert Demmett M.D. M. D. or other

Address 1724 W Lombard St Date signed 6/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

05797 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BALTIMORE

City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
16 Fusting Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Somerset

City or town Crisfield
(If outside city or town limits, write RURAL and give nearest town)

Street No. Richardson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Hattie J Douglas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Henry Douglas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 1860

8. AGE: Years	Months	Days	If less than one day
84	7		..... hrs. ..... min.

9. Birthplace Hopwell Somerset Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John H. Miles
13. Birthplace Somerset CO. Md.

MOTHER
14. Maiden name Lovey Nelson
15. Birthplace Somerset CO. Md.

16. Informant Mr. Nelson Coulbourn

Address Main St. Crisfield Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/45 (month) (day) (year)

Cemetery or crematory Sunnyridge

Location Crisfield Md.

18. Funeral director H. Harvey Bradshaw

Address Crisfield Md.

19. 6/25 1945 C. W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1945, at 8.50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1941, to June 23 1945 and that I last saw h[illegible] alive on June 22 1945

	DURATION
Immediate cause of death Bronchopneumonia	1 wk.
Due to Senile Dementia	6 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallagher M. D.
M. D. or other

Address Crisfield, Md. Date signed 6/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BC)

CERTIFICATE OF DEATH

05798 — 38

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH

County: Baltimore

City or town: Towson Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? 6 yrs - 9 mo - 3 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: McDaniel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Anna Harris Drake

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Sep.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9- 15- 1893

8. AGE:

Years	Months	Days	If less than one day
51	9		hrs. min.

9. Birthplace: Balt Md (Town, county, and state)

10. Usual occupation: Office clerk

11. Industry or business:

FATHER 12. Name: Spedden Harris

13. Birthplace: Md

MOTHER 14. Maiden name: Emma Lohmuller

15. Birthplace: Md

16. Informant: Personal History Hospital Records

Address: Eudowood Sanatorium Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/18/45 (month) (day) (year)

Cemetery or crematory: Olivet Cemetery

Location: St. Michaels Md

18. Funeral director: John O. Mitchell & Son Inc.

Address: 1900 Eutaw Place

19. 6/15 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1945, at 10.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1938, to June 15 1945.

and that I last saw h alive on June 14 1945

Immediate cause of death: Pertussis Pneumonia TBc — DURATION: 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William A Bridges M. D. or other

Address: Towson, Maryland Date signed: 6-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05799

Reg. Dist. No. 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Turner Station
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Turner Station
(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 Burrway
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Drake Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 19, 1931

8. AGE: Years	Months	Days	If less than one day
14			..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER
12. Name: John Drake
13. Birthplace: S. C.

MOTHER
14. Maiden name: Annie Drake
15. Birthplace: S. C.

16. Informant: John Drake

Address: 415 Burrway; Turner Sta.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/19/45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Brooklyn, Md.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley Ave.

19. 6/19/45 (Date rec'd by registrar) 19 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15th 19 45, at 6 3/4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Bronchial Pneumonia	14 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide [illegible] Date of [illegible]

Where did injury occur? [illegible] (City or town) [illegible] (County) [illegible] (State)

Injured at home, farm, industry, public place (where?) [illegible]

Means of injury [illegible] Injured at work?

23. SIGNATURE: [signature] M.D.

Asst. Dep. Med. Exam. - Balto. M.D. or other

Address [illegible] Date signed 6-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

CERTIFICATE OF DEATH

05800

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Balto

City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baalto.

City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Upland Road
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Lawrence A. Eichorn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ella M. Eichorn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	3	..... hrs. ..... min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual occupation Builder

11. Industry or business

FATHER
12. Name John Eichorn
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Bestoll
15. Birthplace Germany

16. Informant Mrs. Ella M. Eichorn
Address Pikesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)

Cemetery or crematory Meadow Branch

Location Carroll Co.

18. Funeral director J. F. Eline & Sons

Address Reisterstown, Md.

19. 6-15 1945 E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 12:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1945, to June 14 1945

and that I last saw him alive on June 13 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	about 2 yrs
Due to	
Due to	
Other conditions Negative autopsy	?

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE E. E. Nichols M.D.
M. D. or other

Address Pikesville Md. Date signed 6/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 05801 38

1. PLACE OF DEATH:

County: BALTIMORE

City or town: TOWSON
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Ten months; eighteen days

Hospital, Institution, or street address where death occurred:
THE SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or institution? Ten months; eighteen days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Bretton Place,
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

KATHERINE CARROLL COOKE FAHEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John T. Fahey

deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 10, 1860

8. AGE: Years	Months	Days	If less than one day
85	4	12	hrs. min.

9. Birthplace: Brooklyn, New York
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Joseph Carroll
13. Birthplace: England

MOTHER
14. Maiden name: Ellen Cooke
15. Birthplace: United States

16. Informant: HOSPITAL RECORDS

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25 1945 (month) (day) (year)

Cemetery or ~~crematory~~: New Cathedral

Location: Balto. Md.

18. Funeral director: Henry W. Hawkins & Sons Co

Address: McCulloh & Orchard Sts

19. 6/23 45 A. W. Nedried Registrar
(Date rec'd by registrar) per mp

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 19 45, at 9:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 1944, to June 22 1945

and that I last saw her alive on June 22 1945

	DURATION
Immediate cause of death: Bronchopneumonia	4 days
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions: Senile psychosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Ross McC. Chapman M.D.
ROSS McC. CHAPMAN, M.D. M. D. or other

Address: TOWSON, MD. Date signed: June 22, 1945

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 N. Rolling Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Christian Fornhals

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margarete Fornhals
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Oct 14. 1889

8. AGE: Years: 55 | Months: 8 | Days: 4 | If less than one day: ...hrs. ...min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Baker

11. Industry or business:

FATHER
12. Name: Jacob Fornhals
13. Birthplace: Germany

MOTHER
14. Maiden name: Wilhelmina Stoll
15. Birthplace: Germany

16. Informant: Margarete Fornhals
Address: 3 N. Rolling Road

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 21, 1945
(month) (day) (year)

Cemetery or crematory: Lorraine
Location: Woodlawn Md.

18. Funeral director: Mr. Mrs. John W. Teufel & Son
Address: 801 W. Fayette St.

19. 6/19/45
(Date rec'd by registrar)
W. L. Lindsey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1945, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 17 1945, to June 18 1945
and that last saw h...im alive on June 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	19 Hrs.
Due to: High Blood Pressure	Months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0
Date of op.:
Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: 0 Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: 0 Injured at work?

23. SIGNATURE: S. Lloyd Johnson
M. D. or other
Address: Catonsville Md. Date signed: 6-19-45.

Dr. Hall
1631 E. North Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

05803 R

Reg. Dist. No.

1. PLACE OF DEATH:
County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Road & Erie Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Harford Road & Erir Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Catherine Franke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Harry E. Franke
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1899

8. AGE: Years	Months	Days	If less than one day
45	5	29	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name Mathew Haensler, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Amelia Ross
15. Birthplace Baltimore, Md.

16. Informant Mr. Harry E. Franke
Address Harford Road & Erie Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/14/45 (month) (day) (year)
Cemetery or crematory Parkwood Cem.
Location Baltimore

18. Funeral director Leonard J. Ruck
Address 5305 Harford Road -14-

19. June 13 1945 (Date rec'd by registrar) A. W. Hedrick per DH Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11th, 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6- 1943, to June 11 1945
and that I last saw h..er alive on June 11- 1945

Immediate cause of death	DURATION
Carcinoma Lo Breast	8 months
Due to	
Due to	
Other conditions Metastasis in Lungs	2 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E Gill Hall MD M. D. or other
Address 1631 E North Ave Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INK OR FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

058C4 43

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County 125 Leslie Avenue
City or town Rural, Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 S. Belnord Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME ANNIE EVELYEN FREUND

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Charles Freund
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1859

8. AGE: Years	Months	Days	If less than one day
85	7	21	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Cook
13. Birthplace Germany

MOTHER
14. Maiden name Eva Catherine Cook
15. Birthplace Germany

16. Informant Mr. Conrad Freund (Son)
Address 29 Sollers Point Road, Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-28-45 (month) (day) (year)
Cemetery or crematory First Evangelical Church
Location Baltimore, Maryland

18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY

19. 6/28 45 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 45, at 5.10 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 19 45, to June 28 19 45
and that I last saw h[illegible] alive on June 28 19 45

Immediate cause of death	DURATION
Ch. Myocarditis	
Due to Chr. Nephritis	
Due to Hypertension	
Other conditions Cerebral Hemorrhage	4 wks
Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph Tenhet M. D.
Address 441 S. Elwood Ave Date signed 6/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94-a

CERTIFICATE OF DEATH

05815

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Bloomsbury Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Daniel Gantt

3.(b) Social Security Number: 215-10-0865

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of ~~husband or~~ wife: Rosa Gantt.

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): January 17, 1886

8. AGE:

Years	Months	Days	If less than one day
59	4	22	...hrs. ...min.

9. Birthplace: Frostburg Md

(Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business

FATHER

12. Name: Conrad Gantt

13. Birthplace: Virginia

MOTHER

14. Maiden name: Rachael Parker

15. Birthplace: Frostburg Md

16. Informant: Delta Lohr

Address: 1419 Alexander Way

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 12/45 (month) (day) (year)

Cemetery or crematory: Loudon Pk.

Location: 3801 Frederick Rd.

16. Funeral director: Harry H. Mistler

Address: 4001 Edmondson Ave.

19. 6/11 19 45 (Date rec'd by registrar) W. C. Andrea Deputy Registrar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-9- 19 45 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4- 19 45, to June 9- 19 45 and that I last saw h. him alive on June 8- 19 45

	DURATION
Immediate cause of death: Angina Pectoris	10 yr
Due to: Coronary Thrombosis	Unknown.
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chester Riland, M.D. (M.D. or Coroner)

Address: 2532 Edmondson Ave, Baltimore Md. Date signed: 6-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

05806 ★ 41

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Balto.

City or town Turners Sta. Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: Day Homes Shores

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County —

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1308 W Lafayette ave

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Alfred Glenn.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-16-1924

8. AGE: Years	Months	Days	If less than one day
21	4	26	..... hrs. ..... min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business .....

FATHER 12. Name Edward Glenn

13. Birthplace S.C.

MOTHER 14. Maiden name Ethel Washington

15. Birthplace SC

16. Informant Timothy Glenn

Address 740 Peach Orchard Lane

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 6 (month) 19 (day) 45 (year)

Cemetery or crematory Winnsboro S.C.

Location Winnsboro S. Carolina

18. Funeral director Williams & Jackson

Address 916 Baltimore-1-Md

19. 6/17/45 19 .....

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .....19..... to .....19.....

and that I last saw h..... alive on .....19.....

Immediate cause of death	DURATION
Drowning (accidental)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes; fill in the following:

Accident, suicide, or homicide Accident Date of 6/17/45

Where did injury occur? Turners Balto. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Street

Means of injury Drowning. Injured at work? No

23. SIGNATURE J M McCarmore M.D.

Deputy Medical Examiner

(M.D. or other)

Address Dundalk Md. Date signed 6/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05807

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Balto. Cockeysville Md
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Balto. County (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Milton Goldberg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife:
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7 1906

8. AGE: Years	Months	Days	If less than one day
40			hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business: Merchant

FATHER
12. Name: Max Goldberg
13. Birthplace: Russia

MOTHER
14. Maiden name: Esther Mitnick
15. Birthplace: Russia

16. Informant: Leon Goldberg
Address: Cockeysville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 11/45 (month) (day) (year)
Cemetery or crematory: Hebrew Friendship
Location: 2600 E. Balto St Balto Md.

18. Funeral director: Sol Levinson Bros.
Address: 1124-26 W North Ave

19. June 8 18 45 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 19 45 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 45 to June 6 19 45 and that I last saw h[illegible] alive on June 6 19 45

Immediate cause of death	DURATION
Carcinoma of Stomach	7
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: F. G. deGuerre M.D. M. D. or other
Address: Towson 4, Md. Date signed: 6/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition of name of town of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (07)

05808

FILM No. G 96 JUL 11 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: Balto Co.

County .....

City or town ..... Hydes

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Hydes

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Earl M. Guy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colod	—

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 9-1941

8. AGE: Years 3 | Months 10 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER — 12. Name Amos Guy

13. Birthplace Hyde Md.

MOTHER — 14. Maiden name Margaret Casterlow

15. Birthplace Md.

18. Informant Amos Guy

Address Hyde Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5-1945 (month) (day) (year)

Cemetery or crematory Mt. Zion Cem.

Location Longview Md.

18. Funeral director Clarence E. Arthur

Address Fork Md.

19 June 4 1945 Clarence E. Arthur

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945 at 4 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 May 1945 to 4 June 1945

and that I last saw h... alive on 4 June 1945

I make the cause of death A. Bronchopneumonia — DURATION 2 wks

Due to .....

Due to .....

Other conditions Cerebral under-development. — 3 yrs 10 mos

(Include pregnancy within 3 months of death)

Major findings of operation .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.

M. D. or other

Address Fork Md. Date signed 6/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

05809

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 9 months, 6 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years, 9 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 614 Melville Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: William N. Guyton

3.(b) Social Security Number: None --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: Gertrude Smith

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 3, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	24	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: ice business

11. Industry or business: owner

FATHER
12. Name: John T. Guyton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura Garrison
15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 6/30/45 (month) (day) (year)

Cemetery ~~or crematory~~: Providence

Location: Hartford Co. Md.

18. Funeral director: William Cook Inc

Address: 1217 St Paul St.

19. 6/29 45 (Date rec'd by registrar) a.w. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27, 1945, at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21, 1942, to June 27, 1945 and that I last saw him alive on June 27, 1945

	DURATION
Immediate cause of death: Intestinal obstruction	8 hrs.
Due to: Volvulus descending colon	8 hrs.
Due to: Incarceration of left scrotal hernia	8 hrs.
Other conditions: Hypertensive cardiovascular disease, chronic	Indef.
	Indef.

(Include pregnancy within 3 months of death)

~~Major findings of operation~~: Fracture of the left hip-9 days: Accidental falls ~~C.W.G.P.~~ Date of op.

Autopsy results: Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of June 12, 1945

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Hospital ward

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D.
Henry C. A. Mead, M. D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 6/28/45

Reg 7-2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05810

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years 2 months 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 3 years 2 months 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ward's Chapel Road - R.D.#2

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Hagel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 20 1860

8. AGE: Years: 85 | Months: 1 one | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Spinster

11. Industry or business: None

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace:

16. Informant: Hospital records: Spring Grove State

Address: Hospital; Catonsville, 28, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 19-45 (month) (day) (year)

Cemetery or crematory: Holy Family

Location: Harrisville, Maryland

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. 6/17 19 45 (Date rec'd by registrar) W. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1945 at 8:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1942, to June 16 1945 and that I last saw her alive on June 16 1945

Immediate cause of death	DURATION
Terminal bronchopneumonia	48 hour
Right lower lobe	
Due to: Chronic myocarditis	Indef.
Due to: Chronic arteriosclerotic cardio-vascular disease	"
Other conditions: Cerebral arteriosclerosis	"
Teratoma kidney pedicle	"

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead, M.D.

Henry C. A. Mead, M. D. M. D. or other

Address: Catonsville, 28, Maryland Date signed: 6/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

05811

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Parkeburg (Golden Ring)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 54 years
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Parkeburg Rural (Golden Ring)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8407 Philadelphia Road
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Joseph HANZLICK (HANZLIK)

3.(b) Social Security Number 218-05-0359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Margaret A. Hanzlik
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 6th 1883

8. AGE: Years	Months	Days	If less than one day
61	9	8	..... hrs. ..... min.

9. Birthplace Czecho-Slovakia (Town, county, and state)
10. Usual occupation Special Officer
11. Industry or business Balto. Co. Police
FATHER 12. Name James Hanzlik
FATHER 13. Birthplace Czecho-Slovakia
MOTHER 14. Maiden name Vorkpovin
MOTHER 15. Birthplace Czecho-Slovakia
16. Informant Mrs Cath. Seiling
Address 8063 Philadelphia Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18 1945 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland
18. Funeral director Lassahn Funeral Home
Address 7401 Belair Road
19. June 15 1945 (Date rec'd by registrar) John D. Cornell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 12:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1945 to June 14 1945 and that I last saw him alive on June 10 1945

Immediate cause of death	DURATION
Cerebral Haemorrhage	2 wks
Due to Hypertensive Cardio Vascular disease	20 yrs
Due to Chronic nephritis	20 yrs
Other conditions Azotemia	?

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Harvey L. Fuller MD (M. D. or other)
Address Ray Road, Balt. 6 Md. Date signed 6-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M. D. B. 1268-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH (12)

05812

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH Baltimore Co. Colgate

~~CITY OF BALTIMORE~~: (No. 548 S 48th St St., Ward)

Length of residence in city or town where death occurred.....yrs.....mos.....ds. How long in U. S. If of foreign birth?.....yrs.....mos.....ds.

2. FULL NAME Veronica Joane Harbach

(a) Residence: No. 548 S 48th St St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E Harbach

6. DATE OF BIRTH (month, day, year) April 10, 1904

7. AGE Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
41	2	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME William Drozt

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Mary Kochan

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Thomas E. Harbach

(Address) 548 S 48th St.

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Rosary Cem. Date 6/27, 1945

19. UNDERTAKER John J. Duda

(Address) 2829 Hudson St

20. FILED 6/25, 1945 A. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 24, 1945

22. I HEREBY CERTIFY, That I attended deceased from Octob. 20, 1945, to June 24, 1945.

I last saw h.er alive on June 23, 1945. Death is said to have occurred on the date stated above, at 1230 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial Asthma	1943 2 yr.

Other contributory causes of importance:

Unknown cause-89	1942

Name of operation None Date of

What test confirmed diagnosis? Phys. Dx Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) J. A. Rosenblatt M. D.

(Address) 3018 O'Donnell St.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver*, etc.

In stating the industry or business avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.*, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

M. D. B. 1268-9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

CERTIFICATE OF DEATH

05813

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 918 Chesapeake Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nathaniel Hatch Nathaniel T. Hatch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Elizabeth Hatch

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): ~~1863~~? March 31, 1853

8. AGE: Years	Months	Days	If less than one day
92 ~~82~~	? 2	? 12	..... hrs. ..... min.

9. Birthplace: ~~Anne Arundel County~~ Baltimore, Md. (Town, county, and state)

10. Usual occupation: Plumber- Well Digger

11. Industry or business: Plumbing

FATHER
12. Name: ? Nathaniel Hatch
13. Birthplace: ? Baltimore, Md.

MOTHER
14. Maiden name: ? Frances A. Wood
15. Birthplace: ? Baltimore, Md.

16. Informant: Hospital records

Address: Catonsville-28, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 15, 1945 (month) (day) (year)

Cemetery or crematory: St. Ann's Cemetery

Location: Annapolis, Md.

18. Funeral director: Miller Lamoreaux

Address: 1005 W. Baltimore St.

19. 6/14 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1945 at 5:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 12 1945

and that I last saw h... alive on June 12 1945

Immediate cause of death	DURATION
Chronic myocardial insufficiency...	Indef.
Due to: Generalized arteriosclerosis and chronic cardio-renal-	
Due to: disease...	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robt. E. Gardner M.D. M. D. or other

Robt. E. Gardner, M.D.

Address: Catonsville-28, Md. Date signed: 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

05814

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3317 Virginia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war W V

3.(a) FULL NAME Pauline Herr

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W.

6.(b) Name of husband or wife Frank Herr
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb. 8-1883

8. AGE: Years	Months	Days	If less than one day
62	4	15	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation —
11. Industry or business

FATHER
12. Name Chris Christoph
13. Birthplace Germany

MOTHER
14. Maiden name Frances Eldus
15. Birthplace Germany

16. Informant Margaret J. Sorensen
Address 801 Frederick Rd. Catonsville

17. Burial Date thereof 6/26/45 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Parkwood Cem
Location Parkville Balto Co.

18. Funeral director W. H. Cook Inc
Address 1217 St Paul St

19. 6/25/45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23-45 19..... at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April-6 19 45; to June-23 19 45;
and that I last saw her alive on June-21 19 45

Immediate cause of death	DURATION
Carcinoma-Spleen	½-1 yr.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations D
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ? Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury D Injured at work? ?

23. SIGNATURE S. Lloyd Johnson MD
M. D. or other
Address Catonsville, Md. Date signed 6-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05815

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 9 months, 8 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 4 years, 9 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 North Fulton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME
George S Hill

3.(b) Social Security Number
--- none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): January 9, 1865

8. AGE: Years	Months	Days	If less than one day
80	5	16	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: factory

FATHER
12. Name: Christopher Hill
13. Birthplace: Virginia

MOTHER
14. Maiden name: Olivia Armshaw
15. Birthplace: Virginia

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Funeral (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)

Cemetery or crematory: Green Hill

Location: Westminster, Md.

18. Funeral director: Fellows Funeral Home

Address: 1211 E. Fort Ave.

19. 6/26 19 45 Reg. No. 325 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25, 1945, at 2:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17, 1940, to June 25, 1945

and that I last saw h...alive on ...19...

	DURATION
Immediate cause of death: Chronic myocardial insufficiency	Indef.
Due to: Chronic arteriosclerotic cardiovascular disease	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 6/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05816

Reg. Dist. No. 40

1. PLACE OF DEATH:

County ~~XXXXXXXXXXXXXXXXXXXX~~ BALTIMORE

City or town Glen Arm

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Glenarm

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clara T Hinder

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Francis J. 37

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 27, 1889

8. AGE: Years 56 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER — 12. Name ? ? Jaschik

13. Birthplace ? ? Austria

MOTHER — 14. Maiden name Theresa ?

15. Birthplace ? ?

18. Informant Mr. Frank Hinder

Address Glen Arm Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 45 (month) (day) (year)

Cemetery or crematory St. Johns

Location Long Green

18. Funeral director Hartlaub & Woods

Address Bunker Hill Md.

19. 6/16/45 19 ..... Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 1944 to June 15 1945 and that I last saw h[illegible] alive on June 14, 1945

Immediate cause of death	DURATION
Carcinoma of uterus with	2 yrs.
Due to Metastasis to	
Due to abdominal wall	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22.–VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.

M. D. or other

Address Fork Md Date signed 6/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 05817

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (97)

County Baltimore County — Registration Dist. No. 38

Village or City Idlewylde — No. 6605 Sherwood Rd St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Duncan C. Horne

(a) Residence: No. 6605 Sherwood Rd St., Ward. S.S.# 218-09-7980

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Rebecca Horne

6. DATE OF BIRTH (month, day, and year) July 3rd 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	11	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Labor Rivers Bran Copp.

10. Date deceased last worked at this occupation (month and yaar)

11. Total time (years) spent in this occupation 22 yrs.

12. BIRTHPLACE (city or town) Glasgow Scotland (State or country)

FATHER

13. NAME Joseph Horne

14. BIRTHPLACE (city or town) Scotland (State or country)

MOTHER

15. MAIDEN NAME Mary S. Maltman

16. BIRTHPLACE (city or town) Scotland (State or country)

17. INFORMANT Mr George Forsyth (Address) 6605 Sherwood Rd.

18. ~~BURIAL, CREMATION, OR~~ REMOVAL Pine Grove Cemetery Place Ansonia, Conn. Date June 25th 1945

19. UNDERTAKER William Cook Inc (Address) 1217 St Paul St

20. FILED 6/25/45 A. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June (Month) 22 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceasad from June 11, 1945, to June 18th, 1945

I last saw h~~im~~ alive on June 22nd, 1945; death is said to have occurred on tha date stated above, at 10.50 A. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Auriculan Fibrillation	June 11/45

Other **Contributory Causes** of importanca:

Arteriosclerosis

Name of operetion Date of

What test confirmed diagnosis? Clinical Was thera an eu'opsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Eldred Roberts M. D.

(Address) Greenspring Road Baltimore 12 Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05818 P

Reg. Diat. No. 45

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Md.

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4117 Eckodale Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I & PTE

3.(a) FULL NAME: FOSTER C. HOWARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White x	Married

6.(b) Name of husband or wife: Mrs. Inza Howard

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): 12-6-88

8. AGE: Years	Months	Days	If less than one day
56	6	12	...hrs. ...min.

9. Birthplace: Delaware
(Town, county, and state)

10. Usual occupation: Doctor

11. Industry or business:

FATHER
12. Name: John H. Howard
13. Birthplace: Penn.

MOTHER
14. Maiden name: Mary ~~Lampson~~ Howell
15. Birthplace: New Jersey

16. Informant: Clinical Records, Vets. Adm.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-22-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Leonard J. Ruck
Address: Balto., Md.

19. 6/20 19 45 (Date rec'd by registrar) A. W. Hedrick per MP Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1945 19 45 at 6:42 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 13, 1945 19 45 to June 19, 1945 and that I last saw him alive on June 19, 1945 19 45

Immediate cause of death	DURATION
Myocardial infarction	
Due to Coronary Occlusion	
Due to Coronary Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. Y. Richards
H.Y. RICHARDS, MAJOR, M.C. M. C. ACT. CLIN.
Address: Ft. Howard, Md. 6/19/45 Date signed: DIR.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93rd)

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 3427 Blenheim Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 05819
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Blenheim Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM SCOTT HUGG

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 219-01-2151
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mary Beeton Hugg
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 9, 1868
8. AGE: Years 76 | Months 7 | Days 8 | If less than one day: hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Manager-Ship supply
11. Industry or business: Spedden Shipbuilding

FATHER
12. Name: John Henry Hugg
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Margaret Susana Jones
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. John Alexander Hugg
(b) Address: 1313 E 35th Street -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) JUN 19 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 12.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 17 1945, to June 17 1945, and that I last saw him alive on June 17 1945

Immediate cause of death	Duration
Chronic Myocarditis & Myocardial Degeneration	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry O'Hare M. D.
Address 2504 St. Paul St. Date signed 6/18/45.

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

05820

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:
14 W. Burke Avenue

How long in hospital or institution? ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 E. Burke Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: --------

3.(a) FULL NAME

NELLIE ELIZABETH HUGHES

3.(b) Social Security Number

----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: --------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): April --1877

8. AGE: Years	Months	Days	If less than one day
68	2	?	....hrs. ....min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business: Private

FATHER
12. Name: Thomas Hughes
13. Birthplace: Ireland

MOTHER
14. Maiden name: Nora Rogers
15. Birthplace: Ireland

16. Informant: Mrs. Patrick J. Kelly
Address: 14 W. Burke Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20, 1945 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore, Maryland

18. Funeral director: John Burns Sons

Address: Towson, Maryland

19. 6/19/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945, to June 17 1945 and that I last saw h alive on June 15 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage (Left)	10 hrs.
Due to: Hypertrophic Arthritis	7-8 yrs.
Due to: Senile Atheromatous Deliriosis	7-8 yrs.
Other conditions: Myocardial Insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operation: .....Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel J. St. Thos. Jenkins M.D. or other

Address: Towson 4, Md. Date signed 6/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-4)

CERTIFICATE OF DEATH

05821

Reg. Diat. No. 8 34

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: Since June 30, 1944
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since June 30, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3216 Abell Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Orlo Bud James

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lola Brown James
8.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.): October 22, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	7	hrs. min.

9. Birthplace: Newport, Ky (Town, county and state)
10. Usual occupation: Statistician
11. Industry or business: Executive-Farm Credit Adm.

FATHER
12. Name: Orlo Davis James
13. Birthplace: Lafayette, Indiana

MOTHER
14. Maiden name: Rose Elizabeth Nulty
15. Birthplace: Lafayette, Indiana

18. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/30/45 (month) (day) (year)
Cemetery or crematory: ?
Location: Richmond, Virginia
18. Funeral director: H. W. Meares and Son
Address: 805 N. Calvert Street

19. 6/30/45 (Date rec'd by registrar) City Health Registrar
Emergency

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29, 1945 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1944 to June 29, 1945 and that I last saw him alive on June 29, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	
Due to:	
Due to:	9 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William A Bridges M. D. or other
Address: Towson, 4 Maryland Date signed: 6-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

7/2/65

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(5822 Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1711 N. Chapel St (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Arthur T. Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): — — 1925

8. AGE: Years: 20 | Months: ? | Days: ? | If less than one day: hrs. min.

8. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER — 12. Name: unknown Arthur T. Johnson

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Margaret Johnson Gibbs

MOTHER — 15. Birthplace: Unknown Md

16. Informant: Hospital records, Address: Catonsville 28 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 30 1945 (month) (day) (year)

Cemetery or crematory:

Location: Cumberland Md

18. Funeral director: John C. Pearson

Address: 3600 E Baltimore St

19. 6/27/45 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945 at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1945, to June 26 1945 and that I last saw him alive on June 26 1945

Immediate cause of death	DURATION
(a) General Paresis	
Due to (b) Juvenile	1 yr
Due to (c) Congenital Syphilis	life
Due to (d)	
Other conditions: Pneumonia Malaria (Include pregnancy within 3 months of death)	10 days

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry A. Mead, M.D. M. D. or other

Address: Catonsville Md Date signed: 6/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49a

05826

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 years
Hospital, institution, or street address where death occurred:
Ridgley Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7721 Philadelphia Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ELIZABETH LILLIE KAPPEL

3.(b) Social Security Number **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife George J. Kappel
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) September 28, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	0	____ hrs. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name --- Lauskey
13. Birthplace Unknown

MOTHER
14. Maiden name Annie Hemer
15. Birthplace Balto., Md.

16. Informant Mrs. John C. Winterstein
Address 7721 Philadelphia Road

17. burial (Burial, cremation, or removal. Which?) Date thereof July 2, 1945 (month) (day) (year)
Cemetery or crematory Parkwood
Location Balto., Md.
18. Funeral director Lanahan Funeral Home
Address 7401 Belair Road

19. 7/1/45 (Date rec'd by registrar) W. W. Emmett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th, 1945, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to June 28, 1945
and that I last saw h. alive on June 27, 1945

Immediate cause of death	DURATION
Generalized Carcinomatosis	3 mo.
Due to Ca of ovary.	4 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harold A. Scott, M.D. M. D. or other
Address 8100 Harford Rd. Date signed 6/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05823

Reg. Diat. No. 80

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Catonsville Nursing home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2417 N. Lanvale St.

(If rural, give LOCATION)

2.(a) If veteran, name war. No

3. (a) FULL NAME Henry F. Karcher

3. (b) Social Security Number None

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Anna M.

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29. 1876

8. AGE: Years 69 | Months 2 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation Baker, Retired

11. Industry or business

FATHER 12. Name Karcher

13. Birthplace Germany

MOTHER 14. Maiden name Friedsecker

15. Birthplace Germany

16. Informant Mrs. Adelgard Karcher

Address 2417 N. Lanvale St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/13/45 (month) (day) (year)

Cemetery or crematory Edgewood

Location U. G. Co. Md.

18. Funeral director Wilhom Funeral Inc.

Address 1217 E. Fayette St.

19. 6/12 1945 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 10 1945

and that I last saw h... alive on June 9 1945

	DURATION
Immediate cause of death Cerebral hemorrhage	2 days
Due to Hypertension C.V. disease	4
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emil Kaltenbrun, M.D. M. D. or other

Address Edmondson Md Date signed 6/14/45

PLEASE WRITE CLEARLY, WITH INDELIBLE INDELIBLE INK. Supply every item of information asked for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05824

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Facility, FT. Howard, Maryland

How long in hospital or institution? 80 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 N. High Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: FRANK KELLY

3. (b) Social Security Number: 220-05-2127

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

8.(b) Name of husband or wife: Widowed

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 15, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	17	..... hrs. ..... min.

9. Birthplace: West Point, Virginia
(Town, county, and state)

10. Usual occupation: Oyster Shucker

11. Industry or business:

FATHER — 12. Name: —

13. Birthplace: —

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Clinical Records, Vet. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-6-45 (month) (day) (year)

Cemetery or crematory:

Location: West Point Va

18. Funeral director: A Lee Alden

Address: 4644 York Rd

19. June 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945 at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1945 to June 2, 1945 and that I last saw him alive on June 2, 1945

Immediate cause of death	DURATION
(a) Coronary occluslon	Immediate
acute.	
Due to: (b) Myocardial Insufficiency.	
Due to: (c) Disease of the heart.	
Due to: (d) Hypertention	
coronary artercosclerosis	
Other conditions: Myocardial Damage.	2 yr.
Gastric Ulcer. (include pregnancy within 3 months of death)	1yr

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Ft Howard Md Date signed 6-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23rd)

CERTIFICATE OF DEATH

05825

Reg. Diat. No. 412

1. PLACE OF DEATH:

County Relay, Balto. County

City or town Relay, Md. 27 zone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 9 mos 25 days.

Hospital, institution, or street address where death occurred:

Relay Sanitarium

How long in hospital or institution? 1 yr 9 mos 25 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or towo limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Holt Lamar

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife Edith S. Lamar

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 20, 1867

8. AGE: Years	Months	Days	If less than one day
77	10	22	..... hrs. ..... min.

9. Birthplace Alabama (Town, county, and state)

10. Usual occupation Attorney at law

11. Industry or business Retired

FATHER 12. Name William Hermang Lamar

13. Birthplace Georgia

MOTHER 14. Maiden name Anna M. Glenn

15. Birthplace Georgia

16. Informant Son - Edw. S. Lamar

Address Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14-45 (month) (day) (year)

Cemetery or crematory Rockville Annex

Location Rockville Maryland.

18. Funeral director Warren E. Humphrey

Address 8434 Georgia Ave. Silver Spring Md.

19. June 12 1945 E. Keefe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1944, to June 11 1945

and that I last saw h... alive on June 11, 1945

Immediate cause of death	DURATION
Heart failure	
Due to Arteriosclerotic cardio-vascular disease	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William J. Bryson M. D. or other

Address St Agnes Hosp Date signed 6/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CI[illegible]TH DEPARTMENT

CERTIFICATE OF DEATH (9-d)

Registered No. [illegible] 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wm. Lynch's Farm Dundalk
(c) Hospital or institution: Balto. Co. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yea or No)
If yes, name country

3 (a) FULL NAME Ventley Mitchell Lawrence

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17-1925

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace Suffolk, Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jackson Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Essie Mitchell
15. Birthplace Va.

16 (a) Informant Essie Civery
(b) Address R.F.D. Box 49, Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bartlett Ave

19 (a) 6/8/45 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pending, chemical analysis: This was negative.
Pending

Due to Chronic myocardial degeneration. C.V.D.
Hypertrophy and dilatation of heart.

Other Conditions Acute pulmonary edema.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wilson M.D.
Medical Examiner.
Date signed 6-4-45
700 Fleet
Balto, Md.

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

05828 B 0
Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: 4114 - 31st Street
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt. Rainier,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Jesse Orlando Lineberry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

8.(b) Name of husband or wife: Ella R. Bennett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 10, 1859

8. AGE:	Years	Months	Days	If less than one day
	85	7	3	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming
FATHER 12. Name: Arlando Lineberry
FATHER 13. Birthplace: North Carolina
MOTHER 14. Maiden name: Cecilia Gillispie
MOTHER 15. Birthplace: North Carolina
18. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 6-13-45 (month) (day) (year)
Cemetery or crematory
Location: Greensboro N C
18. Funeral director: George A Fahey
Address: Catonsville MD
19. 6/13/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 19 45 at 8:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1945, to June 13 1945 and that I last saw him alive on June 13 1945

Immediate cause of death	DURATION
Hydro-nephrosis resulting	
from hypertrophied prostate	3-6 mos.
Due to: Chronic myocarditis	Indef.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robt. E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed 6/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-d)

CERTIFICATE OF DEATH

05829

Reg. Diat. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
5307 Kelly Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5507 Kelly Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Anna Lee MacDermott

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas J. MacDermott
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 4 1860

8. AGE: Years	Months	Days	If less than one day
84	10	9	..... hrs. ..... min.

9. Birthplace: Alexandria Va.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER 12. Name: William J. Price
13. Birthplace: Va.
MOTHER 14. Maiden name: Virginia Madison
15. Birthplace: Va.
16. Informant: William P. MacDermott
Address: 5507 Kelly Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore
18. Funeral director: G. Howard Strong
Address: 3707 W. North Ave
19. June 14 1945 (Date rec'd by registrar) H. E. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1945, at 5:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1945, to June 13 1945
and that I last saw her alive on June 11 1945

Immediate cause of death	DURATION
Acute Cardiac Failure	1 hr.
Due to: Coronary vascular disease ?	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. E. Kieffer M. D. or Coroner
Address: 2470 Mar Blvd Date signed: June 14, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05830

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 23 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 7 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1127 E. Pratt St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Maggio

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Josephine Curcio
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 27, 1889

8. AGE:	Years	Months	Days	If less than one day
	56	2	22	hrs. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Fruit peddler
11. Industry or business: Fruit

FATHER
12. Name: Samuel Maggio
13. Birthplace: Italy

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Italy

16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 1945 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Road
18. Funeral director: Wendell Chappel
Address: 312 S. Washington Ave.

19. 6/19 1945 (Date rec'd by registrar) W. C. Lindsey Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26 1944 to June 18 1945 and that I last saw him alive on June 18 1945

Immediate cause of death	DURATION
Chronic myocarditis	Indef.
Due to: Chronic arteriosclerotic cardiovascular disease	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Maryland Date signed: 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05831 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3510 Lynchester Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME: JOHN AUSTIN MAGUIRE

3.(b) Social Security Number: 705-05-4896

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

8.(b) Name of husband or wife: Eva I. Maguire
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 21, 1895

8. AGE: Years	Months	Days	If less than one day
49	11	19	hrs. min.

9. Birthplace: Boston, Massachusetts (Town, county, and state)
10. Usual occupation: Unemployed - Accountant
11. Industry or business: B. & O. R.R., Balto, Md.

FATHER
12. Name: John Maguire
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Mary Howard
15. Birthplace: New Hampshire

16. Informant: Veterans Administration
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-45 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville Md

18. Funeral director: Wm. J. Tickner & Sons
Address: North & Pennsylvania Ave. Balto, Md.

19. 6/11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 19 45 at 2:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22, 1945, to June 10, 1945 and that I last saw him alive on June 10, 1945

Immediate cause of death	DURATION
Heart Disease --Aortic Insufficiency, Mitral Stenosis, Cardiac	
Due to: Enlargement, Myocardial Insufficiency, Auricular Fibrillation.	5 months
Due to:	plus
Other conditions: Lobular Pneumonia - Terminal	3 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: am Balter Lt Col MC
M. D. or other
Address: Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05832 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 6 Eastelay Rd.
How long in hospital or institution? 1 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6 Eastelay Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Laura Virginia Marshall.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Widow.

6.(b) Name of husband or wife: Greenway Marshall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr 22 1861

8. AGE: Years	Months	Days	If less than one day
84	1	25	hrs. min.

9. Birthplace: Easton, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Jame Plummer
13. Birthplace: md.
MOTHER 14. Maiden name: —
15. Birthplace: —
16. Informant: Mrs. Harry Strasburg
Address: 6 Eastelay Rd. Dundalk.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-20th 1945 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave Road
18. Funeral director: Leo. J. Crook
Address: 1701-03 N Patterson Park Ave
19. 6/19 1945 (Date rec'd by registrar) C. W. Aldrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945 at 3.45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1945 to June 17 1945
and that I last saw h[illegible] alive on 1945

	DURATION
Immediate cause of death: Coronary Occlusion	2 hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. M. Carmine M.D.
Deputy medical Examiner
M. D. or other
Address: Dundalk Md. Date signed: 6/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05833

Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Trump Mill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1606 St. Stephens St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: JAMES L. McCANN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	28	hrs. min.

9. Birthplace: Isplanti, Mich. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER 12. Name: James McCann

13. Birthplace: Ireland

MOTHER 14. Maiden name: Mary J. Smith

15. Birthplace: Isplanti, Mich.

16. Informant: Miss Mary C. McCann, sister
Address: 1606 St. Stephens St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/7/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 6/5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1945, at 7:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1942, to June 4 1945
and that I last saw h-im alive on June 4 1945

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	3 years
Due to	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

SIGNATURE: Leon Ackman M. D.
M. D. or other
Address: 1201 Taylor Ave 84 Date signed: 6-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★115834

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mo.

Hospital, institution, or street address where death occurred: Dance Mill Road, Phoenix

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dance Mill Road

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Charles William McKnew

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Julia Lee Hale

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 11, 1858

8. AGE: Years	Months	Days	If less than one day
87	1		____ hrs. ____ min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Accountant, retired

11. Industry or business

FATHER — 12. Name: Joseph A. McKnew

13. Birthplace: Howard Co. Md.

MOTHER — 14. Maiden name: Louisa Mercer McKnew

15. Birthplace: Howard Co. Md.

16. Informant: Mrs. John Downes, daughter

Address: Phoenix, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (mooth) (day) (year)

Cemetery or crematory: Trinity

Location: Long Green, Balto. Co.

18. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. June 13 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 1945, at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January, 1945 to June 13, 1945 and that I last saw him alive on June 13, 1945.

	DURATION
Immediate cause of death: Heart Disease, Chronic myocarditis	3 yrs ±
Due to: Hypertension	Unk.
Due to: Arteriosclerosis with senile changes.	Unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Rollin C. Hudson M.D. M. D. or other

Address: Towson 4, Md. Date signed 6/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A15


RECEIVED
JUL 2 1968
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 4-5835 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: R.R. Middle River Bridge, Jones Creek

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 151 East St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Jessey Henry Mosley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11-1935

8. AGE:

Years	Months	Days	If less than one day
9			hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Schoolboy

11. Industry or business:

FATHER — 12. Name: H. C. Mosley

13. Birthplace: N. C.

MOTHER — 14. Maiden name: Annie Mae Williams

15. Birthplace: Md.

16. Informant: Anna Mae Mosley

Address: 151 East St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27-1945 (month) (day) (year)

Cemetery or crematory: Mt. Cabbary

Location: H.H. Co. Md.

18. Funeral director: Byron & Mamie H. Wright

Address: 721 Eutaw St. Balto.

19. June 25 19 45 (Date rec'd by registrar) John L. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1945 to June 24 1945 and that I last saw h. alive on 19

Immediate cause of death	DURATION
Drowning	Immediate
Due to: accidental.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of June 24 1945

Where did injury occur? Sparrows Pt. Balto. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury: Drowning. Injured at work? No

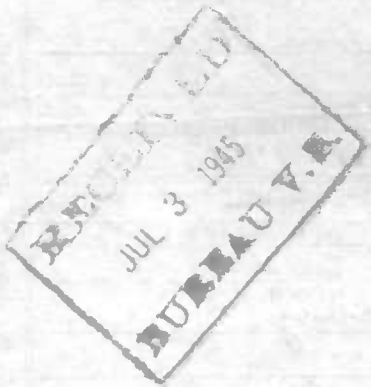
23. SIGNATURE: M. Carmine M.D. Deputy Medical Examiner. M. D. or other

Address: Dundalk Md. Date signed: 6/24/45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 3 1945
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

05836

Reg. Diat. No. 30

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Used Nursing Home

Hospital, institution, or street address where death occurred:

5313 Edmondson Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel County

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5[illegible] Murray Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: Y

3.(a) FULL NAME: Sophia Munford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Whitt Munford

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 5, 1877

8. AGE:

Years	Months	Days	If less than one day
67	7	15	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: School Teacher

11. Industry or business:

FATHER

12. Name: William Tayloe

13. Birthplace: Virginia

MOTHER

14. Maiden name: Sophia R. Plater

15. Birthplace: Maryland

16. Informant: Mrs. James Hood

Address: 5313 Edmondson Ave., Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 23, 1945 (month) (day) (year)

Cemetery or crematory: St. Ann's Cemetery

Location: Annapolis, Md.

18. Funeral director: Ellis Lamoreau

Address: 1003 W. Baltimore St.

19. 6/22/45 (Date rec'd by registrar) 19..... Registrar: [signature] Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1945, at 8.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 20 1945 and that I last saw her alive on June 20 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 Days

Due to: Cerebrae Arteria Sclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Nurse

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 715 Frederick Ave. Catonsville, Md. Date signed: 6-21

Evidence for change of age of deceased is shown on

FILM G 96 JUL 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

05837 P

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County 2408 Taylor av 14
City or town Parkville md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2408 Taylor av
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emory Webster Morrison

3. (b) Social Security Number 717-07-8240

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Rachel Mae Peregoy
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21st 1883

8. AGE: Years	Months	Days	If less than one day
61 ~~62~~	10	28	hrs. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual occupation Trainman
11. Industry or business
FATHER 12. Name Theodore H Morrison
13. Birthplace Green mount md.
MOTHER 14. Maiden name Annie R. Downey
15. Birthplace Balto Md
16. Informant Mrs. Hilda M. Foley
Address 2408 Taylor av
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20 1945 (month) (day) (year)
Cemetery or crematory Woodlawn
Location " Md
18. Funeral director Henry W. Jenkins & Sons
Address McCulloh & Orchard
19. 6/19 1945 (Date rec'd by registrar) A. W. Hedrick Registrar per LCP

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5- 1944 to June 18th 1945 and that I last saw h- alive on June 17th 1945

Immediate cause of death — DURATION

Cardio Renal disease — 2 yrs.

Due to

Due to Arteriosclerosis — 5 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE George G Glass M. D. or other

Address 28 W 25th St Date signed 6-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

05838

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Randallstown, R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infantn give residence of mother)

State Maryland County Baltimore

City or town Randallstown, R.F.D. #1
(If outside city or town limits, write RURAL nnd give nenrest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hannah Mary S. Munshower

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Walter R. Munshower

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 12, 1896

8. AGE: Years	Months	Days	If less than one day
48	9	7	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William H.A. Ridinger

13. Birthplace Maryland

MOTHER 14. Maiden name Lovie Hess

15. Birthplace Maryland

16. Informant Walter R. Munshower

Address Randallstown, R #1, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-22-45 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Harney, Maryland

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. June 21 1945 (Date rec'd by registrar) Harry B. Elins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945, at 7 30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1945, to June 19 1945 and that I last saw h.r alive on not at all. 19

Immediate cause of death	DURATION
Cardiac Decompensation	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op.

Autopsy results

PHYSICIAN: Please nnderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None. Date of

Where did injury occur? (City or town) None. (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, Jr. M. D. or other

Address Reisterstown, Md. Date signed 6-19-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

05839

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Baltimore
City or town: near Anneslie (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 812 Register av
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 6202 York Rd (If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Rebecca Myers
3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age ___ years
7. Birth date of deceased (mo., day, yr.): Aug 12 1876
8. AGE: Years 68 Months 10 Days 4 If less than one day ___ hrs. ___ min.
9. Birthplace: Balto. Md (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Wm G. H. Myers
13. Birthplace: Govans Md
MOTHER 14. Maiden name: Virginia Hannigan
15. Birthplace: Balto Md
16. Informant: Howard Myers
Address: Roland Park Aves
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18 1945 (month) (day) (year)
Cemetery or crematory: Green Mount
Location: Balto Md
18. Funeral director: Henry W. Jenkins & Sons
Address: McCulloh & Orchard St.
19. June 16, 1945 (Date rec'd by registrar) [signature] Registrar, Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945, at 6:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1945, to June 14 1945, and that I last saw her alive on June 15 1945.

Immediate cause of death: Carcinoma Breast — DURATION: [illegible]
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ___ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?

23. SIGNATURE: W H Moody M. D. or other
Address: 1403 Park av. Date signed 6/16/45

Evidence for change of birthdate, shown on microfilm No. G 96 6/28/45 MP

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05840

Reg. Dist. No.

1. PLACE OF DEATH:
County: Balto. Md
City or town: 37 Kenilworth Road (Dundalk)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Same: 37 Kenilworth Rd County: Baltimore
City or town: Baltimore City Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 37 Kenilworth Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Louis Anthony Nichols

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~Feb.~~ 1890 Oct. 28, 1891

8. AGE: Years	Months	Days	If less than one day
53 5/14	7	10	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Electric Foreman
11. Industry or business:
12. FATHER — Name: Vincent Nichols
13. FATHER — Birthplace: Lithuania
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace: " "
16. Informant: Mrs Louis A. Nichols
Address: 37 Kenilworth Road.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-12-1945 (month) (day) (year)
Cemetery or crematory: Parkwood Cemetery
Location:
18. Funeral director: Mary M. Wiedefeld
Address: 501 E 33rd St.
19. June 11 1945 (Date rec'd by registrar) A. M. Hedrick per A.E.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 1945, at 6.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Coronary Occlusion	10 mn.
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. B. Davis M.D.
Asst. Dir. Med. Exam. Public Health Nurse, M.D., or other
Address: Dundalk Md. Date signed: 6/13/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

05841

Reg. Dist. No. 37

VS A15 (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparks (Rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sparks (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Riverville Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Franklin P. Parks

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife: Lena T. (nee Stevens)
6(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1858

8. AGE: Years	Months	Days	If less than one day
86	8	2	____hrs. ____min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Builder
11. Industry or business: Self employed

FATHER
12. Name: Elisha Parks
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Susan Johnson
15. Birthplace: Balto. Co., Md

16. Informant: Mrs. F. P. Parks
Address: Balto. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)
Cemetery or crematory: Jerusalem Church
Location: Sparks, Md.
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. June 5, 1945 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/4/45, 19____, at 12:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____, 19____, to 6/4/45, 19____, and that I last saw him alive on 6/2/45, 19____.

Immediate cause of death: Carcinoma of Cecum
Due to: Cachexia
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

DURATION: 8 mos.

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: James M. Saffell M. D. or other
Address: Westminster Md. Date signed 6/6/45

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

CERTIFICATE OF DEATH

05842 41

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Glendale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 year

Hospital, Institution, or street address whers death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Glendale

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 2524 York Way

(If rural, give LOCATION)

2.(a) I1 veteran, name war

3. (a) FULL NAME Mabbie A PARSONS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Nama ol husband or wife: John L Parsons

6.(c) I1 alive, gives age: 47 years

7. Birth date ol deceased (mo., day, yr.): Oct 11 - 1900

8. AGE: Years	Months	Days	If less than one day
44	7	21	....hrs. ....min.

9. Birthplace: Queen City Mauricia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: House

FATHER — 12. Name: John Johnson

FATHER — 13. Birthplace: Kentucky

MOTHER — 14. Maiden name: Katherine Henderson

MOTHER — 15. Birthplace: Kentucky

16. Informant: John L Parsons

Address: 2526 york Way

17. Burial (Burial, cremation, or removal, Which?) Dats thereol: June 6 - 1945 (month) (day) (year)

Csmetery or crematory: Druid Ridge Cem

Locatloo

18. Funeral director: Charles T Powell

Address: 2427 Edmondson Ave

19. June 4 19 45 (Date rec'd hy registrar) A. W. Kedrick Registrar

A.E.D.

MEDICAL CERTIEICATION

20. DATE OF DEATH: 6-2-45 19.... at 10 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended decsased from ....19...., to ....19....

and thal I last saw h....alive on ....19....

Immediate cause ol death: Carbon-Monoxide Poisoning

DURATION: 2-3h.

Due to:

Due to:

Other conditions:

(Iuclude pregnancy within 3 months of death)

Major findings ol operations: ....Date ol op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Suicide

Accident, suicide, or homicide: Date ol 6-2-45

Whers did injury occur? Dundalk (City or town) Baltimore (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Turned on gas at home Injured at work?

23. SIGNATURE: M D Bowers M.D.

Asst Supt. Med. Exam. (M.D. or other)

Address: ....Date signed 6-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of inf rmation carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05843

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years, 29 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 7 years, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Pearl Pattleford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Reech
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 2, 1859

8. AGE:	Years	Months	Days	If less than one day
	86	2	27	...hrs. ...min.

9. Birthplace: Paris, France (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7-20-45 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland

19. 7/20 19 45 (Date rec'd by registrar) H. C. Cookerly Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1945, at 12:35a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1938, to June 29 1945 and that I last saw him alive on June 29 1945

Immediate cause of death	DURATION
Right lower lobe, terminal pneumonia	3 days
Due to: Chronic hypertensive cardio-vascular disease with chornic myo-carditis	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other
Address: Catonsville, Balto.-28 Md. Date signed 7/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

15844

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto.
City or town: Turners Sta (Dundalk)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Bay Village Store
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Balto. City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1308 N. Lafayette Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Taft Pearson.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Charlotte.
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 9-11-1920

8. AGE: Years	Months	Days	If less than one day
24	9	6	hrs. min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: James Pearson
13. Birthplace: S. C
MOTHER 14. Maiden name: Vassie Gatson
15. Birthplace: S.C.
16. Informant: Timothy Glenn
Address: 740 Peach Orchard Lane
17. Shipped (Burial, cremation, or removal—Which?) Date thereof: 6 (month) 19 (day) 45 (year)
Cemetery or crematory: Winsboro cemetery
Location: Winsboro South Carolina
18. Funeral director: William A Jackson
Address: 916 Penna Ave Baltimore Md
19. 6/17/45 (Date rec'd by registrar) J M Learmonth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Accidental Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 6/17/45
Where did injury occur? Turners Sta. Balto. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Store Bay Village
Means of injury: Drowning. Injured at work? No

23. SIGNATURE: J M Learmonth M.D.
M. D. or other
Address: Dundalk, Md. Date signed: 6/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05845

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:
Owings Mills

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Warfield Smith Pierce

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Minnie Tracey Pierce

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): July 25 - 1867

8. AGE: Years	Months	Days	If less than one day
77	10	13	...hrs. ...min.

9. Birthplace: Butler - Balto Co - Md
(Town, county, and state)

10. Usual occupation: Retired Blacksmith

11. Industry or business: None

FATHER
12. Name: Caleb Pierce
13. Birthplace: Unknown

MOTHER
14. Maiden name: Anna Gill
15. Birthplace: Unknown

16. Informant: Mrs. Rachel Gaugh

Address: 2112 N.Fulton Ave Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 11 1945 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Reisterstown Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. June 10 1945 (Date rec'd by registrar) Mary B. Elmore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-8- 1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-27 1941 to 6-8 1945 and that I last saw him alive on 6-6- 1945

Immediate cause of death	DURATION
Cardiac Decompensation	6 mon.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Eppler, M. D. M. D. or other

Address: Reisterstown, Md. Date signed: 6-9-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

115846

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7801 Oak Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Lizzie Pool

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

9.(b) Name of husband or wife: Charles

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 3. 1853

8. AGE: Years	Months	Days	If less than one day
92	3	4	....hrs. ....min.

9. Birthplace: Baltimore Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Charles Henry

13. Birthplace: Md

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

19. Informant: Henry T. Schafer

Address: 7801 Oak Ave Parkville Md

17. Burial

(Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year) 6/18/45

Cemetery or crematory: London Park

Location: Baltimore Md

19. Funeral director: Nelhom Funeral Home

Address: 1217 E. Pratt St

19. June 16 19 45 A. W. Hedrick Registrar

(Date rec'd by registrar) a.e.s.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 19 45 at 4:30 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 4 19 44, to June 13 19 45

and that I last saw h.. ex alive on June 13 19 45

Immediate cause of death

		DURATION
(a) Secondary	Carcinoma of Colon	3 years
(b) Primary	Carcinoma bladder	2½ years
Due to	Metastasis	
Due to	Chronic asthenia	
Other conditions	Inanition	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. V. Harold M.D.

M. D. or other

Address: 4706 Harford Road Date signed: 6/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

05847

Reg. Diat. No. 39

1. PLACE OF DEATH:

County: Baltimore

City or town: Phoenix (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Phoenix (Rural)
(If ontside city or town limits, writs RURAL und give nearest town)

Street No.: Paper Mill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Clara J. Price

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1862

8. AGE: Years	Months	Days	If less than one day
82	6	7	hrs. min.

9. Birthplace: Balto. Co. md.
(Town, county, and state)

10. Usual occupation: Homemaker

11. Industry or business:

FATHER
12. Name: Joshua Price
13. Birthplace: Balto. Co. Md

MOTHER
14. Maiden name: Elizabeth Kelley
15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. J. Albert Price
Address: Phoenix, Balto Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5 1945 (month) (day) (year)

Cemetery or crematory: Glyndon Cemetery

Location: Reisterstown, Md (Rural)

18. Funeral director: Lemuel M. Snyder

Address: Sparks, Md

19. June 4 1945 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1942, to June 3 1945 and that I last saw h[illegible] alive on June 2, 1945.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to: Hypertensive Cardiovascular disease	7 yrs
Due to:	
Other conditions: Cholelithiasis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D. M. D. or other

Address: Fork, Md Date signed 6/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

05848

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred: Opitz Home

How long in hospital or institution? 3 4 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1821 W. Mosher St. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Elizabeth M Reith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 9 1868

8. AGE: Years 77 | Months 5 | Days 4 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Saleswoman

11. Industry or business:

FATHER 12. Name: Peter Reith

13. Birthplace: Germany

MOTHER 14. Maiden name: Frances J Trupp

15. Birthplace: Germany

16. Informant: Edward F Reith

Address: 1714 Moreland Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-16-45 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore Md

18. Funeral director: Geo. A Fahey

Address: Catonsville Md

19. 6/15 19 45 (Date rec'd by registrar) W. C. Lutkehaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 19 45 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45, to June 14 19 45 and that I last saw h.. alive on June 14 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Generalized Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Catonsville Md Date signed: 6/15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Inf. re residence obtained by phone from Opitz Home on 6/12/45. ams.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

05849 P

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Hrs.

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 14 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town 1462 Stevenson St.

(If outside city or town limits, write RURAL and give nearest town)

Street No. See above

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME WILLIAM H. RICE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Lilly Rice

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) May 29, 1884

8. AGE: Years	Months	Days	If less than one day
61		23	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name George Rice

13. Birthplace ?

MOTHER 14. Maiden name Elizabeth Cornell

15. Birthplace ?

16. Informant Clinical Records, Vets. Adm. Fac.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25-45 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director A. Howard Evans

Address 1400 S. Charles St., Balto., Md.

19. 6/23 45 (Date rec'd by registrar) A.W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1945 19..... at 3:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1945 19..... to June 22, 1945 and that I last saw him alive on June 22, 1945 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Hypertension and Coronary Arteriosclerotic heart disease	3 Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE A.M. BALTER

Address A.M. BALTER, LT. COL., M.C. MED. DIR. Fort Howard, Md. Date signed 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05850

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4201 Milford Mill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CARRIE MAY RICHMOND

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James M. Richmond

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1867

8. AGE: Years	Months	Days	If less than one day
78	1	20	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Stockett
13. Birthplace: Md.

MOTHER
14. Maiden name: Eliza Williams
15. Birthplace: Md.

16. Informant: Mr. James M. Richmond, Sr.
Address: 4201 Milford Mill Rd., Pikesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/11/45 (month) (day) (year)

Cemetery or crematory: Western Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 6/9 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945, at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1941, to June 8 1945 and that I last saw h[illegible] alive on June 7 1945

Immediate cause of death: Cardio vascular hypertensive disease — DURATION: 6 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Homer C. Todd MD
M. D. or other

Address: 735 N. Fulton Ave. Date signed: 6/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13F) Reg. Dist. No. 05851

CERTIFICATE OF DEATH

1. PLACE OF DEATH
(a) County Baltimore
(b) City or town REISTERSTOWN, MD (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: MT. PLEASANT SANATORIUM
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76 days
(e) Length of stay in this community (yrs., mos., or days) "

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Park Heights Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? 32 years

3 (a) FULL NAME Joseph Rizinsky
3 (b) If veteran, name war
3 (c) Social Security No. 131-03-8310

4. Sex M. | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife ESTHER RIZINSKY
6. (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1905

8. AGE: Years 39 | Months 8 | Days 25 | If less than one day ____hr. ____min.

9. Birthplace CHORSNE, RUSSIA (Town, county, and state)
10. Usual occupation WATCHMAKER
11. Industry or business

FATHER
12. Name MORRIS RIZINSKY
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ANNA DOREMAN
15. Birthplace RUSSIA

16 (a) Informant ESTHER RIZINSKY
(b) Address 4221 PARK HEIGHTS AVE

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-10-45 (month) (day) (year)
(c) Cemetery or crematory
Location New York City

18 (a) Funeral director Jack Lewis, Inc
(b) Address 1439 E Balto St

19 (a) June 16, 1945 (Date rec'd by registrar) (b) Herrington Williams Registrar

MEDICAL CERTIFICATION

20. Date of death June 10, 1945, at 7.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 27, 1945, to June 10, 1945, and that I last saw him alive on June 10, 1945.

Immediate cause of death	Duration
Myocardial Failure,	
Due to	
Due to Pulmonary Tuberculosis since 1922 For adjustment	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature DR. ALBERT F. Shrier M. D. or other
Address MT. PLEASANT SANITARIUM, REISTERSTOWN, MD Date signed June 10, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

05852

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1752 Brookview Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Bell Rogers.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: J. Kenneth Rogers
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): July 12 - 1889

8. AGE: Years	Months	Days	If less than one day
55	11		hrs. min.

9. Birthplace: Eagel Pa
(Town, county, and state)

10. Usual occupation:
11. Industry or business: At Home

FATHER
12. Name: Harry S Keets
13. Birthplace: Pa

MOTHER
14. Maiden name: Elizabett Deary
15. Birthplace: Pa

16. Informant: J. Kenneth Rogers
Address: 1752 Brookview Rd

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 29 45 (month) (day) (year)
Cemetery or crematory: Lawnwood Presbyterian Cem
Location: Glenmore Pa

16. Funeral director: Holland Funeral Home
Address: 200 Oaleen

19. 6/28 1945 C. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27th 1945 at 12 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1944 to June 27 1945
and that I last saw h alive on June 25 1945

Immediate cause of death	DURATION
Epidermoid Carcinoma of Sigmoid	
Due to: Secondary Metastases	13 Mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Sigmoid
Date of op. May 1944
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. B. Davis M.D.
M. D., or other
Address: Dundalk Md Date signed 6/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

05853 41

Reg. Dist. No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mutual Chemical Co. Plant

How long in hospital or institution? Elapsed time

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 833 Edmondson Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Thomas Joseph Rogers

3.(b) Social Security Number: 217-07-9363

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Elizabeth H. Rogers

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 3, 1909

8. AGE: Years	Months	Days	If less than one day
35	9	14	hrs. min.

9. Birthplace: Oxford North Carolina (Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

MOTHER FATHER

12. Name: Charles Rogers

13. Birthplace: North Carolina

14. Maiden name: Ruth Downing

15. Birthplace: North Carolina

16. Informant: Elizabeth H. Rogers

Address: 833 Edmondson Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 20 1945 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore Maryland

18. Funeral director: Charles K. Law

Address: 802-04 Madison Avenue

19. 6/19/45 (Date rec'd by registrar) 19 J. McCarmine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to June 17 1945

and that I last saw h alive on 19

Immediate cause of death	DURATION
Drowning	
Due to (a) Accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 6/17/45

Where did injury occur? Dundalk (City or town) Baltimore (County) Md. (State)

Injured at home, farm, industry, public place (where?): Public place

Means of injury: Drowning Injured at work? No.

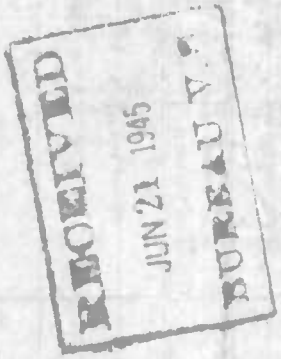
23. SIGNATURE: J. McCarmine M.D. Deputy medical examiner (M.D. or other)

Address: Dundalk Md. Date signed: 6/19/45

6 00

1/2 022

115 — 30



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05854 P

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1703 Guilford Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I ✓

3.(a) FULL NAME WILLIAM A. ROSE

3.(b) Social Security Number 219-01-3044

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-24-1892

8. AGE:	Years	Months	Days	If less than one day
	52	5	9	..... hrs. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Theatrical Business & Bookkeeper

11. Industry or business

FATHER 12. Name William D. Rose
13. Birthplace West Virginia

MOTHER 14. Maiden name Ella J. Blanchard
15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. Fac.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-8-45 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Frederick Rd Ft.

18. Funeral director A. Lee Oler
Address 4644 York Rd.

19. 6-8 19 45 ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1945, at 2:15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to June 4, 1945 and that I last saw him alive on June 4, 1945

Immediate cause of death	DURATION
Myocardial Damage	
Due to	
Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John U. Leiser, Jr MC AUS, M. D. or other
Address Fort Howard, Md. Date signed 6/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3)

CERTIFICATE OF DEATH

★05855

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Relay (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days 14½ hrs

Hospital, institution, or street address where death occurred: Relay Sanitarium

How long in hospital or institution? 3 days 14½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto

City or town Balto (If outside city or town limits, write RURAL and give nearest town)

Street No. 2246 Eutaw Place (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Max L. Rosenfeld

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Rose Rosenfeld

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1878

8. AGE:

Years	Months	Days	If less than one day
67			..... hrs. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Designer

11. Industry or business Clothing Factory

FATHER

12. Name Meyer Rosenfeld

13. Birthplace Russia

MOTHER

14. Maiden name Reba (Unknown)

15. Birthplace Russia

16. Informant Mrs. Howard Plant (daughter) Address 2246 Eutaw Pl Rad. 7313 R.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-17-45 (month) (day) (year)

Cemetery or crematory Rosedale

Location Hapulton Ave

18. Funeral director Jack Lewis, Inc

Address 1439 E Balto St

19. 6/17 19 45 R. C. Pendergast (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17-45 19 ..... at 3 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-13-45 19 ..... to 6-17-45 19 .....

and that I last saw h..... alive on 6-16-45 19 .....

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 mos
Due to Arteriosclerosis	
Due to	
Other conditions Senile Psychosis	1 mos

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James Howard M. D. or other

Address Baltimore Md Date signed 6-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Howell
715 Frederick Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

05856

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

20 Woodley Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Woodley Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Frederick Rudolph.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	W.

6.(b) Name of husband or wife Addie Grace Rudolph.

6.(c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1861

8. AGE: Years	Months	Days	If less than one day
84	4	2	....hrs. ....min.

9. Birthplace Dont Know, (Town, county, and state)

10. Usual occupation Gardener

11. Industry or business —

FATHER 12. Name Dont Know

FATHER 13. Birthplace Dont Know

MOTHER 14. Maiden name Dont Know

MOTHER 15. Birthplace Dont Know

16. Informant William Rudolph.

Address 20 Woodley Ave. Reisterstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19, 1945 (month) (day) (year)

Cemetery or crematory Asbury

Location Reisterstown, Md

18. Funeral director Wm. Berryman & Sons

Address Reisterstown, Md.

19. June 18 1945 (Date rec'd by registrar) Mary B. Elkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-11 1944, to 6-16 1945 and that I last saw h... alive on 6-15 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	2½ yrs.
Due to	
Due to	
Other conditions Prostatic Hypertrophy	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D. M. D. or other

Address Reisterstown, Md Date signed 6-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 05857

REGISTERED G96 JUN 21 1945

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6507 York Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 6507 York Rd
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Henrietta Ruhl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1874

8. AGE: Years 70 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace York, Penna.
(Town, county, and state)

10. Usual Occupation at home.

11. Industry or business

FATHER
12. Name Wm Daniel Beckler
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah Miller
15. Birthplace Pa.

16 (a) Informant James Kennedy
(b) Address 6507 York Rd.

17 (a) Burial (b) Date thereof 6-13-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem
Location York Penna.

18 (a) Funeral director Leonard F. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b) Registrar
(Delivered by registrar)

JUN 14 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to 6/11 1945, and that I last saw her alive on 6/10 1945.

Immediate cause of death	Duration
Hypertension Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury Kyle W. Holley

23. Signature Kyle W. Holley M. D.

Address 5703 Harford Rd Date signed 6/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

05858

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 19 Hanover Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Raymond R,Russell

3.(b) Social Security Number: 218-01-6733

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude J.Russell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 28,1881

8. AGE: Years	Months	Days	If less than one day
63	10	22	..... hrs. ..... min.

9. Birthplace: Balto.Co.
(Town, county, and state)

10. Usual occupation: Manager Social Security Dept.

11. Industry or business: Consolidated Engineering Co.

FATHER
12. Name: Reister Russell
13. Birthplace: Penna.

MOTHER
14. Maiden name: Catherine Ducker
15. Birthplace: Balto.Co.

16. Informant: Maude J.Russell
Address: Reisterstown,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22,1945 (month) (day) (year)

Cemetery or crematory: All-Saints

Location: Balto.Co.

18. Funeral director: J.F.Kline & Sons
Address: Reisterstown,Md.

19. June 22 1945 (Date rec'd by registrar) Mary B. Kline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-19 1945, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-18 1944 to 6-19 1945 and that I last saw him alive on 6-17 1945

Immediate cause of death	DURATION
Angina Pectoris	8 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) None (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. D. Caplan, M.D. M. D. or other

Address: Reisterstown, Md. Date signed 6-21 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (183)

Registered No. 05859

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore ~~City~~ County, Maryland
(b) Street address
(c) Hospital or institution: Loch Raven (Old Dulaney Pike Pool)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Joppa (If outside city or town limits, write RURAL and give town)
(d) Street No. Clayton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John L. Schuman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-18-5012

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mar 6, 1924

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 21 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER 12. Name George A Schuman

13. Birthplace Maryland

MOTHER 14. Maiden Name Alice Seymour

15. Birthplace Maryland

16 (a) Informant Alice Emanuel

(b) Address Joppa Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Trinity Lutheran

Location Joppa Md

18 (a) Funeral director Howard E. McCormick

(b) Address Abingdon Md

19 (a) 6/25/45 C. W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1945, at 6 30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8 to 9 P.M. at 6-21-45 M.

(b) Where did injury occur? Old Dulaney Pike Pool Loch Raven

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Found Drowned

23. Signature Roland Lee Graham M.D. Medical Examiner.

Date signed June 24 1945

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05860

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Balto.

City or town: Fullerton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: 8717 Wendell Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Fullerton P O (If outside city or town limits, write RURAL and give nearest town)

Street No. 8717 Wendell Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles O. Seiler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Annie M. Seiler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 5th 1866

8. AGE: Years	Months	Days	If less than one day
78	8	6	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Baker

11. Industry or business

FATHER — 12. Name: Louis F Seiler

13. Birthplace: Germany

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Pauline Blackburn

Address 8717 Wendell Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 (month) 14 (day) 45 (year)

Cemetery or crematory: Mt. Carmel

Location: Balto. Md

18. Funeral director: Lassahn Funeral Home

Address 7401 Belair Rd

19. June 13 1945 (Date rec'd by registrar) Mrs. P. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11th 1945 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to 6/11 1945

and that I last saw him alive on 6/4 1945

Immediate cause of death: Cerebral Hemorrhage	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wyatt Godley M. D. or other.

Address 5703 Harford Rd Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

33

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1860)

CERTIFICATE OF DEATH

05861

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Middle Run Victory Villa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Victory Villa Gardens
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 E. Midland Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Glenn Clay Sigmon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 - 1937

8. AGE: Years 8 | Months 1 | Days 10 | If less than one day hrs. min.

9. Birthplace Julian, W. Va.
(Town, county, and state)

10. Usual occupation Schoolboy

11. Industry or business

MOTHER FATHER
12. Name Belva Sigmon
13. Birthplace W. Va.
MOTHER
14. Maiden name Eva Fencher
15. Birthplace W. Va.

16. Informant Belva Sigmon
Address 7 E. Midland Rd.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/21/45 (month) (day) (year)

Cemetery or crematory
Location Julian, W. Va.

18. Funeral director John F. Connelly
Address 418 Eastern Ave. Erie

19. 6/21/ 1945 John F. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 19 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fractured Skull	
Left Parietal	30 min.
Due to Fall from Tree	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 6-19-45
Where did injury occur? Victory Villa - Balto - Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) In Yard
Means of injury Fell from Tree Injured at work? No

23. SIGNATURE R B Davis M.D.
Asst Dept. Med. Exam - Balto Co. M. D. or other
Address Towson Md. Date signed 6-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (23d)

Reg. Dist. No. 44

05862

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Balto.
(b) City or town Middle River (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No Phila. Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Mary Jane Simms

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Andrew J. Simms 6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 29, 1863

8. AGE: Years 82 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Chas. Burton
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Eliz. Fowler
15. Birthplace Balto. Co. Md

16 (a) Informant Mrs. King
(b) Address Middle River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (month) 15 (day) 45 (year)
(c) Cemetery or crematory Waugh Chapel
Location Balto Co. Md

18 (a) Funeral director Sassaman Funeral Home
(b) Address 7401 Belair Rd.

19 (a) June 14 45 (Date rec'd by registrar) (b) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. Date of death June 12 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 12 1945, and that I last saw him alive on June 12 1945.

Immediate cause of death Cerebral apoplexy — Duration 3 days

Due to Arteriosclerosis

Due to Cardio-Vascular disease

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo M. Baumgardner M. D., or other

Address Balto 6 Date signed 6/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-f)

CERTIFICATE OF DEATH

05863

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(MARGIN RESERVED FOR BINDING)

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Nospital, Institution, or street address where death occurred:

Vets. Adm. Fac., Ft. Howard, Md.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Fullerton, (If outside city or town limits, write RURAL and give nearest town)

Street No. 7540 Belair Road (If rural, give LOCATION)

2.(a) If veteran, name war: WW I & PTE

3.(a) FULL NAME: Louis Simone

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Beulah Simone

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 2-8-98 ??

8. AGE:	Years	Months	Days	If lese than one day
	47	4	14	....hrs. ....min.

9. Birthplace: Italy (Town, county, and state)

10. Usuat occupation: Watkins Dealer

11. Industry or business:

FATHER

12. Name: Anthony Simone

13. Birthplace: Italy

MOTHER

14. Maiden name: Marie ?

15. Birthplace: Italy

16. Informant: Clinical Recrods Vets. Adm.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Baltimore, Maryland

18. Funerat director: Lessahn Funeral Home

Address: Baltimore, Md.

19. June 29 1945 (Date rec'd by registrar) Dawson Pearbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24, 1945 19..., at 4:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1945, to June 24 1945 and that I last saw him alive on June 24 1945

Immediate cause of death	DURATION
Tumor of Superior Mediastinum, Malignant. Cell.	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Balter

A. M. BALTER, LT. COL. MC. Brother DIR.

Address: Ft. Howard, Md. Date signed: 6/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45) BC

CERTIFICATE OF DEATH

05864

★ Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Govans
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Mercy Villa, Bellona Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Govans
(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 Enfield Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME OSCAR T. SMITH

3.(b) Social Security Number 212-18-5858

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife Edna Bradshaw Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 19th, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	23	....hrs. ....min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual occupation Printing

11. Industry or business Stationery

FATHER
12. Name Louis L. Smith
13. Birthplace N. C.

MOTHER
14. Maiden name Nancy Green
15. Birthplace N. C.

16. Informant Mr. Oscar T. Smith, Jr.

Address 116 Enfield Rd., Balto., Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/13/45 (month) (day) (year)

Cemetery or crematory

Location Durham, N. C.

18. Funeral director Lasasha Funeral Home

Address 7401 Belair Road

19. June 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th, 1945 at 11:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..45 to June 9 19..45 and that I last saw h.. alive on June 8 19..45

Immediate cause of death	DURATION
Carcinoma of Hard Palate	8 mos.
Due to Metastasis to Brain	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ulcerating carcinoma of hard palate Date of op. Dec 1944

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis W. Gluck M.D.
M. D. or other

Address 715 Park Ave Date signed 6/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

05865

Reg. Dist. No. 38

1. PLACE OF DEATH.
County Baltimore
City or town 420 E. Pennsylvania ave
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years Towson Md
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Towson Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 420 E. Pennsylvania ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ralph Clayton Smith

3.(b) Social Security Number 218-18-1905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife Bessie Shaw
6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April 16, 1896

8. AGE: Years 49 | Months 2 | Days | If less than one day ... hrs. ... min.

9. Birthplace Balto Co Md
(Town, county, and state)

10. Usual occupation Ironmn Wash Depot

11. Industry or business

FATHER 12. Name William Smith
13. Birthplace Germany

MOTHER 14. Maiden name Mary J. Miller
15. Birthplace Baltimore Md

16. Informant Mrs Bessie Smith
Address 420 E. Pennsylvania ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3-1945 (month) (day) (year)
Cemetery or crematory Pine Grove
Location White Hall R. F. D.

18. Funeral director Howard L. Markline
Address White Hall Md

19. June 30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1945 at 5:30 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1944 to June 29 1945
and that I last saw him alive on June 29, 1945

Immediate cause of death	DURATION
Myocardial Decompensation	2 yrs.
Due to Arteriosclerosis	
Due to Hypertension	mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stuart Kelly M.D.
M. D. or other
Address Towson 4 Md Date signed 6/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

05866 P

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Baltimore
City or town Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since January 30, 1945
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since January 30, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2513 Taylor ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lemuel Gilbert Sparks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lorraine Sparks
6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 26, 1894

8. AGE: Years 45 Months 12 Days If less than one day hrs. min.

9. Birthplace Custer Kent Co Md
(Town, county, and state)

10. Usual occupation Pressman

11. Industry or business Balty News-Post

FATHER 12. Name William Gilbert Sparks
13. Birthplace Custer Md

MOTHER 14. Maiden name Mary Gardner
15. Birthplace Chester Md

16. Informant Personal History Hospital Records
Address Eudowood Sanatorium Towson 4 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-9-45 (month) (day) (year)
Cemetery or crematory Mowlad M. Park
Location Balto

18. Funeral director L. J. Ruck
Address 5305 Harford Rd.

19. 6-8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945, at 6:40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 30 1945, to June 6 1945
and that I last saw him alive on June 6 1945

Immediate cause of death Pulmonary tuberculosis — DURATION: Since April 1944

Due to — DURATION:

Due to — DURATION:

Other conditions — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William A Bridges M. D.
Address Towson 4 Maryland Date signed 6-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05867

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto - 2
City or town: 653 Avondale Rd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos
Hospital, Institution, or street address (where death occurred): 653 Avondale Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Hanover
City or town: Sassuell
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 1 Box 114
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Spencer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widowed

6.(b) Name of husband or wife: John Spencer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 9, 1884
8. AGE: Years: 60 Months: 0 Days: 0 If less than one day: hrs. min.
9. Birthplace: Caroline Co. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: unknown
13. Birthplace:
MOTHER 14. Maiden name: unknown
15. Birthplace:
16. Informant: Mrs. Wm. Farmer
Address: 653 Avondale Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-15-45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location:
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.
19. 6-15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12, 1945, at 4 00 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1945, to June 12, 1945 and that I last saw h[illegible] alive on June 12, 1945
Immediate cause of death: Carcinoma of Cervix uteri — DURATION
Due to: Unknown
Due to:
Other conditions: none
(Include pregnancy within 3 months of death)
Major findings of operation: none Date of op.: none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arthur Straith, M.D. M.D. or other
Address: 101 Brookmeade Date signed: 6-28-45

Dr. Harbold
Harford Road

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

05868

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Parkville
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
7601 Old Harford Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Parkville
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7601 Old Harford Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Stella R. Sternat

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: August H. Sternat
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	21	hrs. min.

9. Birthplace: Louisiana (Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: ----Moyd
13. Birthplace: Spain

MOTHER
14. Maiden name: ------
15. Birthplace: ------

16. Informant: Mr. August H. Sternat
Address: 7601 Old Harford Road -14-

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/25/45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Baltimore
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road -14-

19. 6-23-45 (Date rec'd by registrar) 19.... A. M. Bacow Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21st., 1945, at 12:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1st 1944, to June 20 1945
and that I last saw h.er alive on June 20 1945

Immediate cause of death	DURATION
Coronary thrombosis	3 days
Due to: Coronary sclerosis	
Due to: Arteriosclerosis	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. V. Harbold M.D. M. D. or other
Address: 4706 Harford Road Date signed: 6/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05869

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 47 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1504 Eutaw Place

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2 & PTE

3.(a) FULL NAME: HENRY C. STITZ

3.(b) Social Security Number: 47-18-3693

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Stitz

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): June 22, 1901

8. AGE:	Years	Months	Days	If less than one day
	43	11	9	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Blender

11. Industry or business

FATHER — 12. Name: Adam W. Stitz

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Marie Dieker

15. Birthplace: Germany

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial - (Burial, cremation, or removal. Which?) Date thereof: 6/5/45 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall, Md.

18. Funeral director: Wm. J. Tickner

Address: North Ave & Penn. Balto., Md.

19. 6/5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1, 1945 19..... at 7:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1945 19..... to June 1, 1945 and that I last saw him alive on June 1, 1945 19.....

Immediate cause of death	DURATION
Malnutrition	3 Mos.
Due to: Carcinoma of the Stomach	Unknown
Due to:	
Other conditions: Metastatic carcinoma of the liver, peritoneum, mesenteric and retroperitoneal lymph nodes	

(Antecedent causes. Morbid conditions, if any, giving rise to the above cause, stating the underlying cause last. Do not enter modes of dying, such as cardiac failure, asphyxia, anemia, or uremia. Do not enter merely the mode of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. M. Balter, Lt. Col., M.C.

M.D. or Coroner

Address: Fort Howard, Md. Date signed: 6-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

05870 43

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

3711 Putty Hill Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Fullerton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3711 Putty Hill Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY AMELIA BELL STOKES

3. (b) Social Security Number

--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John Stokes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 2nd, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	6	..... hrs. ..... min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: William Bell

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary L. Curran

15. Birthplace: Md.

16. Informant: Mrs. B. L. Taylor

Address: 3711 Putty Hill Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore, Md.

16. Funeral director: Loveland Funeral Home

Address: 7401 Belair Road

19. June 10 19 45 Mrs. B.L. Reifsnider

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8th, 19 45 at 6:15A. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/4 19 45 to 6/8 19 45

and that I last saw h... alive on 6/8 19 45

Immediate cause of death: Chronic Pulmonary Tuberculosis

DURATION

Due to:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. C. Colley M. D. or other

Address: 6703 Harford Rd. Date signed 6/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05871

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Balto.

City or town: Millers Island, mailing Rte

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 919 Renfrew Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Diana Tutchton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 12 - 1938

8. AGE:

Years	Months	Days	If less than one day
7	5	16	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Schoolgirl

11. Industry or business

FATHER

12. Name: ?

13. Birthplace: ?

MOTHER

14. Maiden name: Marion Tutchton

15. Birthplace: Baltimore

16. Informant: Lillian Stromberg

Address: 919 Renfrew St. Essex

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2 - 45 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Eastern Ave. Road

18. Funeral director: John G. Connolly

Address: 418 Eastern Ave. Essex

19. June 30 1945 (Date rec'd by registrar) John G. Connolly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1945 at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowning (accidental)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of injury: June 28 1945

Where did injury occur? Off Millers Isl. Balto. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Public Place

Means of injury: Drowning Injured at work? No

23. SIGNATURE: J. M. Learmonth M.D.

M. D. or other

Address: Deputy Medical Examiner Date signed: 6-29-45

Baltimore Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

05872

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Balto.

City or town: Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto.

City or town: Middle River P.O.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Seneca Park

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence H. Unverzagt

3.(b) Social Security Number: 213-10-0846

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Mary G. Unverzagt

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 20th 1895

8. AGE: Years	Months	Days	If less than one day
49	9	7	..... hrs. ..... min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: F.H.A.

FATHER — 12. Name: —

13. Birthplace: —

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Mary G. Unverzagt

Address: Seneca Park Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6 30 45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Balto. Md

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd.

19. July 2 1945 Dawson L. Parker

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27th 1945 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1943 to June 27 1945

and that I last saw him alive on June 27 1945

	DURATION
Immediate cause of death: Coronary Insufficiency	2 yrs
Due to: Essential Hypertension	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of Injury: — Injured at work? —

23. SIGNATURE: Paul R. Estep MD

M. D. or other

Address: 510 Middle River Rd. Date signed: June 27-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05873 P

Reg. Dist. No. 80

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3422 East Baltimore Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Verges

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lena Reisinger

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): August 1st, 1864

8. AGE: Years	Months	Days	If less than one day
80	10	23	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Building

FATHER

12. Name: Louis Verges

13. Birthplace: Unknown

MOTHER

14. Maiden name: Elizabeth -?

15. Birthplace: Unknown

16. Informant: Hospital records - Spring Grove State

Address: Hospital, Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-26-45 (month) (day) (year)

Cemetery or crematory: Emmanuel

Location: Frederick Ave

18. Funeral director: John C. Melly Inc

Address: 3431 E. Oliver St

19. 6/25/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23, 1945 19.... at 12:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 1945 19.... to June 23 19 45 and that I last saw him alive on June 23rd, 1945 19....

Immediate cause of death	DURATION
Chronic myocardial insufficiency	Indefin.
Due to: Chronic hypertensive cardio-renal disease with generalized	
Due to: arteriorsclerosis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry A. Mead, M.D. M. D. or other

Henry A. Mead, M. D.

Address: Catonsville, 28, Maryland Date signed: 6/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05874 9

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since May 14, 1945
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since May 14, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2007 Ridgehill Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Martin Warch (Warchi)

3.(b) Social Security Number 212-16-8655

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hilda R. Warch
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): June 27, 1905

8. AGE: Years	Months	Days	If less than one day
39	11	8	...hrs. ...min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Shipyard Worker Rigger
11. Industry or business: Md. Drydock
FATHER 12. Name: John Warch
FATHER 13. Birthplace: Greece (Savannah)
MOTHER 14. Maiden name: Elizabeth Meisner
MOTHER 15. Birthplace: Baltimore Md
16. Informant: Personal History Hospital Records
Address: Eudowood Sanatorium Towson 4, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/8/45 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 6/6 '45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1945 at 7:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1945 to June 5 1945 and that I last saw him alive on May 15 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	Onset December 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William A. Bridges M. D.
Address: Towson 4 Maryland Date signed: 6-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

05875

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore

City or town Loudon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1903 Hammonds Ferry Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Loudon

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1903 Hammonds Ferry Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George H. Ward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary A Ward

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 5 1901

8. AGE:

Years	Months	Days	If less than one day
44	2	16	..... hrs. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Fisherman

11. Industry or business B & O R R

FATHER 12. Name Samuel A Ward

13. Birthplace Md

MOTHER 14. Maiden name Alice Dilley

15. Birthplace Md

16. Informant Mary A Ward

Address 1903 Hammonds Ferry Rd

17. Buried Date thereof 6-25-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore

18. Funeral director Wm Cook Funeral

Address 1217 St Paul St

19. June 22 1947 G E Kieffer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947 at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
a prostatectomy	
Due to Cardiovascular disease	
Due to sudden death	
Other conditions Pregnancy	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE G E Kieffer Asst Med Exam Balto

M. D. or other

Address 1010 Leadenhall Date signed 6-21-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05876

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs., 10 mos., 14 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 21 yrs., 10 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9 Fort Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Weaver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 22, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	30	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Odd jobs

FATHER
12. Name: Henry Weber
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mollie Forsythe
15. Birthplace: Baltimore, Md.

16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-2-45 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland

19. 7/2/45 (Date rec'd by registrar) H. C. Lindsay Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 1923 to June 21 1945 and that I last saw him alive on June 21 1945

Immediate cause of death	DURATION
Gangrene (with hemorrhage, 4 hours), infectious bi-	
Due to: lateral, buttocks	5 days
Due to: Septicemia, undetermined etio-	
logy	Indefinite
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other
Robert E. Gardner, M.D.

Address: June 22, 1945 Catonsville, Balto.-28, Maryland Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of wife's name shown on paper in Perm. File under "Webster" 7/25/45 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

05877

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 5 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 410 West Fayette Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel Lee Webster

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~Anna McElwee~~ Rebecca Y. Betts *

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 17, 1882

8. AGE:	Years	Months	Days	If less than one day
	63	1	10	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Sheet metal worker
FATHER 12. Name: John A. Webster
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Matilda Billmire
MOTHER 15. Birthplace: Maryland
16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof 6-29-45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto.
18. Funeral director: L. J. Ruck
Address: 5305 Harford Rd.
19. 6/28 45 (Date rec'd by registrar) 19.. A. W. Nedrich per [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 45 at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 19 45, to June 26 19 45 and that I last saw him alive on June 26 19 45

Immediate cause of death	DURATION
Terminal purulent right broncho pneumonia	7 hrs.
Due to: Hypertensive arteriosclerotic cardiovascular-renal disease	Indef.
Due to: Old right hemiplegia	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robt. E. Gardner, M.D. M. D. or other
Address: Catonsville, Balto. 28, Md. Date signed: 6/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of ~~information~~ carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05878

P

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 5107 Leeds Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5107 Leeds Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Thomas Welden

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida C. Welden
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	7	hrs. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Rice Bakery
FATHER 12. Name: William T. Welden
13. Birthplace: Md.
MOTHER 14. Maiden name: Mollie Arlow
15. Birthplace: Md.
16. Informant: Mrs. Ida C. Welden
Address: 5107 Leeds Ave., Arbutus, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/13/45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 6/13 19 45 Alo Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10, 1945 at 12⁰¹ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 42 to June 10 19 45 and that I last saw h.im alive on June 8 19 45

Immediate cause of death	DURATION
Cardio Vascular Degenerative Disease	15 yrs
Due to: Heart failure	2 days.
Due to: Coronary Occlusion	12 minutes
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Earl Pass M.D. M. D. or other
Address: 4001 Wilkens Ave Date signed: 6-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05879

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 2 months, 24 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 5 years, 2 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1722 Byrd Street (If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Thomas R. Wheeler

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: unk.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 15, 1874

8. AGE: Years	Months	Days	If less than one day
71	5	6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: W.P.A.

FATHER 12. Name: Jim Wheeler

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: ? Ellmore

MOTHER 15. Birthplace: United States

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: A. A. Co. Md.

18. Funeral director: Flynn & Flenniken

Address: 1426 Eutaw St. Balto. Md.

19. 6/23/45 (Date rec'd by registrar) H. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1945 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1940, to June 21, 1945 and that I last saw him alive on June 21, 1945

Immediate cause of death	DURATION
Bilateral lower lobar pneumonia; terminal	2 days
Due to Generalized arteriosclerotic C.V. Disease	indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed 6/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

05880 38 P

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
812 Regester Ave.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3110 Gwynns Falls Pkwy.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME BEULAH BENTON WHITE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Timbrook White
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2, 1874

8. AGE: Years	Months	Days	If less than one day
70	11	7	..... hrs. ..... min.

9. Birthplace Fairmount, Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name William E. Ford
13. Birthplace Fairmount, Md.

MOTHER
14. Maiden name Metka E. Muir
15. Birthplace Fairmount, Md.

16. Informant Mrs. Wendell H. Baker
Address 3110 Gwynns Falls Parkway

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/12/45 (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 6/11 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1945, at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 19 1944 19..., to June 9 1945 and that I last saw h.. alive on June 8 19...45

	DURATION
Immediate cause of death Cerebral Hemorrhage + paralysis	about 5 mo.
Due to Advanced Arteriosclerosis + Hypertension	p
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Walter D. Mullett M. D. or other
Address 2220 Harrison Blvd Date signed Jan 11 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

05881

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: .....
Hospital, institution, or street address where death occurred: Belle Grove Rd.
How long in hospital or institution?: .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Belle Grove Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: NELLIE WIEST

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. A. Wiest
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 5, 1864

8. AGE: Years	Months	Days	If less than one day
80	11	26	..... hrs. ..... min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Richard Read
13. Birthplace: England

MOTHER
14. Maiden name: Unknown
15. Birthplace: England

16. Informant: Mr. W. Read Wiest
Address: Belle Grove Rd., Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/4/45 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 6/4 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1, 19 45, at 6:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 19 44, to June 1 19 45
and that I last saw h[illegible] alive on 5/30 19 45

Immediate cause of death	DURATION
Intracranial Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A H Crowther M D
M. D., or other
Address: 409 Bud Ave Date signed: 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05882 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 7 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore-21
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Larry Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Wiley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Lillian Bursey

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 28, 1896

8. AGE:	Years	Months	Days	If less than one day
	49	1	21	____ hrs. ____ min.

9. Birthplace: Reedville, Virginia
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Carpentering

FATHER
12. Name: James A. Wiley
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Ellen Cooksie
15. Birthplace: Baltimore

16. Informant: Hospital records

Address: Catonsville-28, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20 1945 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Eastern Ave. Road

18. Funeral director: John G. Connelly

Address: 418 Eastern Ave., Essex

19. 6/20 19 45 G. W. Kedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 19 45 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 19 45, to June 18 19 45 and that I last saw him alive on June 18 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to: Central nervous system syphilis	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91a)

CERTIFICATE OF DEATH

05883

★ 37

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Monkton (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or towo: Monkton (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Corbett Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Clarence Dorsey Wilson

3. (b) Social Security Number: 220-01-0519

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Katie (nee Stitely)

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 7, 1875

8. AGE: Years	Months	Days	If less than one day
70	—	18	..... hrs. ..... min.

9. Birthplace: Balto. Co. Maryland (Town, county, and state)

10. Usual occupation: Machinist & Painter

11. Industry or business: Black & Decker Mfg. Co.

FATHER 12. Name: Wm. D. Wilson

13. Birthplace: Phila., Pa.

MOTHER 14. Maiden name: Mary Ryan

15. Birthplace: Balto. Co. Md.

18. Informant: Mrs. C. D. Wilson

Address: Monkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27 1945 (month) (day) (year)

Cemetery or crematory: Hereford Baptist

Location: Hereford, Balto. Co. Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 6-26 45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 1945, to June 25 1945

and that I last saw h... alive on June 24 1945

Immediate cause of death	DURATION
Cardiac Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Milton Boston M.D. M. D. or other

Address: White Hall Date signed: June 25 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

05884

CERTIFICATE OF DEATH

Reg. Dist. No. 57

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Texas

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Baltimore County Home

Stay in hospital or inst. (yrs., or mos., or days) 6 yr. 9 mo. 22da

Stay in this community (yrs., or mos., or days) 6 yr. 9 mo. 22da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Harry Wilson

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Widower

6 (b) Name of husband or wife Sophie Dennis

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. ? 1860

8. AGE:

Years	Months	Days	If less than one day
84 yr.	about 10	?	hrs. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Wilson

13. Birthplace Unkown

MOTHER 14. Maiden name Jane ?

15. Birthplace Unkown

16. Informant Balto. Co., Home Register

Address Texas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23 1945 (month) (day) (year)

Cemetery or crematory Balto. Co. Home Cemetery

Location Texas. Md.

18. Funeral director Lankom Brooks

Address Sparks. Md.

19. June 22 1945 (Date rec'd by registrar) Wm. J. Whitcomb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 45, at 10 30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1938, to June 22 1945, and that I last saw him alive on 6/21 1945.

	DURATION
Immediate cause of death Chronic Nephritis (Uraemic Coma.)	3 days
Due to Arteriosclerosis	5 yrs.
Due to Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Holmes C. Eusor M.D. M. D. or other

Address Cockeysville Md. Date signed 6/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05885

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Sparrows Point Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Ship yard.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto. City
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 507 N. Kenwood ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME George C. Wolf.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: anna L.

7. Birth date of deceased (mo., day, yr.): Sept. 19 - 1880

6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
64 ~~58~~	9		hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Copper smith
11. Industry or business: Bath. Steel.
12. FATHER Name: John Wolf
13. Birthplace: Germany
14. MOTHER Maiden name: Elizabeth Lichtfbuck
15. Birthplace: Balto.
16. Informant: Anna L. Wolf
Address: 507 N. Kingsford Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 22-44 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Rd.
18. Funeral director: John A. Moran
Address: 3000 E. Balto. St
19. 6/20 19 45 H. W. Hedrick Registrar
(Date rec'd by registrar) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 19 45, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	Immediate
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. McCarmine M.D.
M. D. or other
Address: Deputy Medical Examiner Date signed: 6/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05886

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel County

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence M. Woolley

Florence Woolley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 1, 1859

8. AGE: Years	Months	Days	If less than one day
85	9	12	..... hrs. ..... min.

9. Birthplace: Cecil County, Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Charles C. Woolley

13. Birthplace: Cecil County, Md.

MOTHER

14. Maiden name: Elizabeth A. White

15. Birthplace: Philadelphia, Pa.

16. Informant: Mr. George E. Woolley

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15, 1945 (month) (day) (year)

Cemetery or crematory: St. Ann's Cemetery

Location: Annapolis, Md.

18. Funeral director: Willis Lamoreau

Address: 1003 W. Baltimore St.

19. 6/14/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1945 to June 13, 1945 and that I last saw h... alive on June 13, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Arteriosclerosis	5 yrs
Due to:	
Other conditions: Fracture of Femur (Include pregnancy within 3 months of death) Accidental fall. cystic	3 mos

Major findings of operations: Fracture of Femur

Date of op. Feb. 6, 45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: February 17, 1945

Where did injury occur? Catonsville (City or town) Baltimore (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Opitz Nursing Home

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Lucie Howard M. D. or other

Address: Catonsville Date signed 6/13

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05887

Reg. Dist. No. 33-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Stone Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: White Hall R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry J. Wright

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rosa E. Wright
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 17 1866

8. AGE:

Years	Months	Days	If less than one day
79	6	27	hrs. min.

9. Birthplace: Baltimore Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm Work
FATHER 12. Name: Henry S. Wright
13. Birthplace: Baltimore Co. Md.
MOTHER 14. Maiden name: Sarah Rogers
15. Birthplace: Baltimore Co. Md.
16. Interment: Baltimore Md.
Address: Stone Hill
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 16 1945 (month) (day) (year)
Cemetery or crematory: Mt. Lebanon
Location: Stone Hill Md.
18. Funeral director: W. Thomas Fitz
Address: Fair Play Pa.
19. June 17 1945 (Date rec'd by registrar) Estelle L. Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1945 at 2 40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943 to June 13 1945
and that I last saw him alive on June 12 1945

Immediate cause of death	DURATION
Uremia	
Due to: Chronic interstitial nephritis	
Duration: one year.	
Due to:	
Other conditions: Generalized arteriosclerosis, Hypertension, chronic	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. M. France M. D. or other
Address: Parkton, Md. Date signed: 6/14/45